NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, FEBRUARY 4, 2021
2:00 P.M.

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

BOARD OF DIRECTORS

Supervisor Andrew Do, Chair	Isabel Becerra, Vice Chair
Supervisor Doug Chaffee	Clayton Chau, M.D.
Clayton Corwin	Mary Giammona, M.D.
Victor Jordan	J. Scott Schoeffel
Trieu Tran, M.D.	Vacant

Supervisor Lisa Bartlett, Alternate

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

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form identifying the item 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 and/or the beginning of Public Comments. When addressing the Board, it is requested that you state your name for the record. Address the Board as a whole through the Chair. Comments to individual Board Members or staff are not permitted. Speakers are limited to three (3) minutes per item.

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

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

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

1) **Listen to the live audio at +1 (213) 929-4212 Access Code: 938-885-530 or**
2) **Participate via Webinar at** https://attendee.gotowebinar.com/register/3618106151485698061 **rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
None.

MANAGEMENT REPORTS
1. Chief Executive Officer Report
   a. Biden Administration
   b. Proposed FY 2021–22 State Budget
   c. California Advancing and Innovating Medi-Cal (CalAIM)
   d. Be Well OC Campus Opening
   e. COVID-19 Vaccination Efforts
   f. Medi-Cal Enrollment Awareness
   g. Medi-Cal Rx Transition
   h. Employee Engagement Survey

2. COVID-19 Update

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
3. Minutes
   a. Approve Minutes of the December 3, 2020 Regular Meeting of the CalOptima Board of Directors
   b. Approve Minutes of the January 7, 2021 Special Meeting of the CalOptima Board of Directors

4. Consider Approval of Modifications to Policy GG.1643: Minimum Physician Standards

5. Consider Ratification of Modifications to CalOptima Policy and Procedure GG.1352 Private Duty Nursing Care Management of Medi-Cal Eligible Members under the Age of 21

6. Consider Authorizing Modification and Extension of License Agreement with the County of Orange for Use of Space at the Orange County Community Service Center Annex

7. Consider Authorization of Contract with Legislative Tracking Services Vendor and Proposed Budget Reallocation of Fiscal Year 2020–21 Operating Budget Funds

8. Consider Approval of Reimbursement for Necessary Business Expenditures Incurred by Employees on Temporary Telework Due to the Coronavirus (COVID-19) Pandemic

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

10. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Bridge Period Contract Amendment

11. Consider Selection and Award of Contract for Vision Services Vendor

12. Consider Authorizing an Amendment to Extend the Program of All-Inclusive Care for the Elderly (PACE) Contract with Mediture for Electronic Health Record Services

13. Consider Ratification of an Enterprise Agreement with Dell Corporation for Access to Microsoft Products

14. Consider Authorization of Expenditures in Support of CalOptima Participation in Community Event

15. Consider Authorizing an Amended and Restated Health Network Contract for Kaiser Foundation Health Plan Inc. and Amendments Incorporating Operational Provisions and Revised Capitation Rates

16. Consider Authorizing Extension of Federal Legislative Advocacy Services Contract with Akin Gump Straus Hauer & Feld LLP

17. Receive and File:
    a. November and December 2020 Financial Summaries
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Community Outreach and Program Summary

REPORTS

18. Consider Actions Related to Implementation of CalOptima's COVID-19 Vaccine Strategy

19. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers for Mitigation of COVID-19-Related Expenses

20. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Hospitals for Mitigation of COVID-19 Related Expenses

21. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for Mitigation of COVID-19-Related Expenses

22. Consider Reallocation of Intergovernmental Transfer (IGT) 9 Funds Allocated for Virtual Urgent Care (eVisit) to Support both eVisit and eConsult Implementation During Coronavirus (COVID-19) Pandemic and Beyond

23. Consider Ratifying Amendments to the Medi-Cal Shared-Risk Physician Group, Physician Hospital Consortium, and Health Maintenance Organization Health Network Contracts, Except Kaiser Foundation Health Plan, Inc.

ADVISORY COMMITTEE UPDATES

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

BOARD MEMBER COMMENTS

CLOSED SESSION

CS-1 Pursuant to Government Code Section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. Kindred Hospital – Westminster and Kindred Hospital – Santa Ana, et al. v. CalOptima et al. (Orange County Superior Court Case No.: 30-2020-01140494-CU-BC-CJC)

ADJOURNMENT

How to Join

1. Please register for Regular Meeting of the CalOptima Board of Directors on February 4, 2021 at 2:00 PM PDT at: https://attendee.gotowebinar.com/register/3618106151485698061

2. After registering, you will **receive a confirmation email containing a link to join** the webinar at the specified time and date.

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

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

3. **Choose** one of the following **audio options:**

   TO USE YOUR COMPUTER'S AUDIO:

   When the webinar begins, you will be connected to audio using your computer's microphone and speakers (VoIP). A headset is recommended.

   --OR--

   TO USE YOUR TELEPHONE:

   If you prefer to use your phone, you must select "Use Telephone" after joining the webinar and call in using the numbers below.

   United States: +1 (213) 929-4212

   Access Code: 938-885-530

   Audio PIN: Shown after joining the webinar

MEMORANDUM

DATE:	January 27, 2021
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, Chief Executive Officer
SUBJECT:	CEO Report — February 4, 2021 Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

Biden Administration Will Bring Changes to Federal Health Care Priorities
On January 20, President Joe Biden and Vice President Kamala Harris were inaugurated. President Biden's top priority is COVID-19 response and vaccine distribution, with a goal of administering 100 million vaccines within his first 100 days in office. Shortly after being sworn in, he took executive action to rejoin the World Health Organization, restore the Obama-era White House global health security office, and mandate the use of masks on all federal properties and by all federal employees. The new Administration also released an outline of a $1.9 trillion COVID-19 relief plan, which would require approval by Congress. Elements include $20 billion for a national vaccination program, $50 billion for testing, $30 billion for medical supplies and personal protective equipment, and $350 billion for state and local governments. Related to Medicaid, the president wants to increase the Medicaid Federal Medicaid Assistance Percentage to 100% for vaccine administration fees, strengthen and expand the Affordable Care Act, and address racial and ethnic health care disparities. Democrats' new majority in the Senate may put other health care policies within reach, such as the creation of a public option or Medicare early buy-in plan. I will keep your Board informed of key federal health policy changes going forward.

Proposed State Budget Increases Medi-Cal Funding, Reintroduces Plans for Innovation
On January 8, 2021, Gov. Gavin Newsom released the proposed Fiscal Year 2021–22 State Budget. As California continues to respond to the public health emergency, Gov. Newsom's proposed budget expands upon existing health care programs while reintroducing proposals that were delayed due to last year's budget restraints and the COVID-19 pandemic. Among other health care actions, the proposed budget includes $122.2 billion in Medi-Cal spending (a 6% increase from the prior year), extends funding for Medi-Cal optional benefits until 2022 and reintroduces the California Advancing and Innovating Medi-Cal (CalAIM) proposal. California has until July 1, 2021, to enact a state budget. Following my report is CalOptima's analysis of the proposed budget.

CalAIM Proposal Relaunched, Enhances Care Coordination for High-Risk Members
Concurrent with the release of Gov. Newsom's FY 2021–22 proposed budget, the Department of Health Care Services (DHCS) released a revised CalAIM proposal. CalAIM is a multiyear initiative to improve Medi-Cal beneficiaries' quality of life and health outcomes by implementing delivery system, program and payment reforms. The proposal was initially released in late 2019 but put on hold due to the pandemic. The new proposal revitalizes the Enhanced Care Management and In Lieu of Services initiatives and calls for implementation on

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January 1, 2022. CalAIM's relaunch also brings the restart of state-sponsored workgroups this month, with a plan to finalize requirements in the spring. CalOptima will participate in the state's stakeholder-feedback process and has begun local coordination efforts by meeting with the Orange County Health Care Agency (HCA) on January 22. Soon, CalOptima will also engage our advisory groups, health networks, provider associations, community collaboratives and others to ensure awareness of the significant elements in CalAIM. A white paper summarizing CalAIM initiatives follows my report.

Be Well OC Campus in Orange Ready to Serve With Integrated Mental Health System
On January 13, CalOptima was proud to be part of an outstanding virtual ribbon cutting event for the Be Well OC campus in Orange. Representing CalOptima as a contributing partner to the campus, I was included among the speakers asked to highlight the benefits of the transformed and integrated mental health care system. My message emphasized the value of Be Well's seamless continuum of care and the availability of enhanced Medi-Cal services for CalOptima members. Starting on January 25, members have access to sobering stations to recover safely from substance use and receive additional services or referrals. On February 1, Be Well's crisis stabilization unit will be operational to support members experiencing an acute mental health crisis. View the recorded event here.

COVID-19 Vaccination Efforts Focus on Collaboration, Communication
CalOptima's activity has shifted to raising vaccine awareness and speeding distribution. Below are summaries of selected efforts surrounding vaccination response.

- *Vaccine Equity Pilot Program:* On January 26, the Board of Supervisors approved a COVID-19 Vaccine Equity Pilot Program to support CalOptima, our health networks and community clinics in serving targeted Medi-Cal members with co-morbidities over the age of 65. The program will add resources at vaccination sites specific for these members and promote availability of the vaccine through targeted outreach. The goal is to reach up to 96,000 CalOptima members.
- *Program of All-Inclusive Care for the Elderly (PACE) Vaccination Clinic:* In a collaborative effort between PACE, HCA, Mercy Pharmacy Group and Othena, CalOptima held the first of four COVID-19 vaccine clinics at the Garden Grove PACE center on Saturday, January 23. Vaccines were administered to 172 PACE participants and 54 staff. The next clinic is January 28, and the third and fourth clinics are in late February to administer the second dose. The event was a success, with many participants and the family members who transported them expressing emotions of joy and relief.
- *Long-Term Care Vaccination:* CalOptima's Long-Term Care nurses conduct biweekly phone calls with contracted nursing facilities and have recently added vaccination data collection to their check-ins. Data from late January, from 52 of 70 facilities reporting, indicates that more than 2,600 CalOptima nursing home members have been vaccinated thus far.
- *Vaccine Hesitancy Survey:* In response to the directive at your Board's Special Meeting on January 7, CalOptima will conduct a vaccine hesitancy survey of our members. The Population Health Management team will collaborate with HCA staff to leverage the HCA vaccine hesitancy survey results and identify unanswered questions to include in the CalOptima survey. We will design appropriate or alternative survey methodology that will lead to actionable plans to address the root causes of vaccine hesitancy, focusing on CalOptima's hard-to-reach and most vulnerable populations.

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- *Vaccination Advertising Campaign:* Launching in February, CalOptima's vaccination ad campaign has been approved by the state and shared with the County for coordination. The first part of the campaign emphasizes placement in local newspapers, including English, Spanish and Vietnamese language papers. Starting in March, ads for billboards, transit shelters, Spanish radio and social media will be added. The campaign will run through the end of June, and across that period, we will introduce new ad designs to keep the campaign fresh. Further, we are working closely with the County to leverage our media buy.
- *Media Coverage:* The Board-approved $35.4 million program to offer two $25 incentives for members to receive the vaccine drew significant media coverage on January 20. The Orange County Register ran an article on the front page, and KABC's 3 p.m. and 6 p.m. news also mentioned the incentives in a larger story about vaccination sites. See the link here.

Medi-Cal Enrollment Awareness Material Shared Broadly in the Community
Considering the pandemic's economic impact on individuals, CalOptima's Community Relations team is reaching out to organizations that serve potential members. This month, the team connected with more than 80 community-based groups, collaboratives, shelters and affordable housing developers to raise awareness about the Medi-Cal eligibility and application process and supply electronic educational material in CalOptima's threshold languages of English, Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese. Nearly 40 of the organizations have already requested printed copies of the materials, posted information their websites and social media platforms, or shared information with their clients.

Medi-Cal Rx Transition Still Anticipated for April 1
On January 6, DHCS held a webinar to provide an update regarding the transition to Medi-Cal Rx. DHCS staff stated that go-live remains April 1, and the state distributed a member notice in late December with that implementation date. Magellan discussed its launch of Transitional Support Services (TSS), with responsibilities that include operating a customer service support center, expanding web portal functionality and providing managed care plan training with Magellan clinical liaisons. CalOptima will meet twice with the clinical liaison team this month. Between now and April 1, the TSS call center will respond to questions about Medi-Cal Rx, web functionality, and training and education, but will not assist with questions about member eligibility, authorizations or claims. Separate yet relevant to Medi-Cal Rx, Centene Corp. announced January 4 that it is acquiring Magellan.

CalOptima Completes Employee Engagement Survey Data Collection
To share their feedback, 1,085 employees (77%) completed The Pulse Employee Engagement Survey this month. Next, the survey vendor will compile and analyze the results by approximately March, and CalOptima leaders will use the findings to identify opportunities to strengthen engagement. A prior employee survey was conducted in July 2019 and resulted in several enhancements, including an Employee Engagement Team, a peer recognition program and education on strategic goal setting.

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California State Budget: FY 2021-22 Proposal Analysis

January 2021

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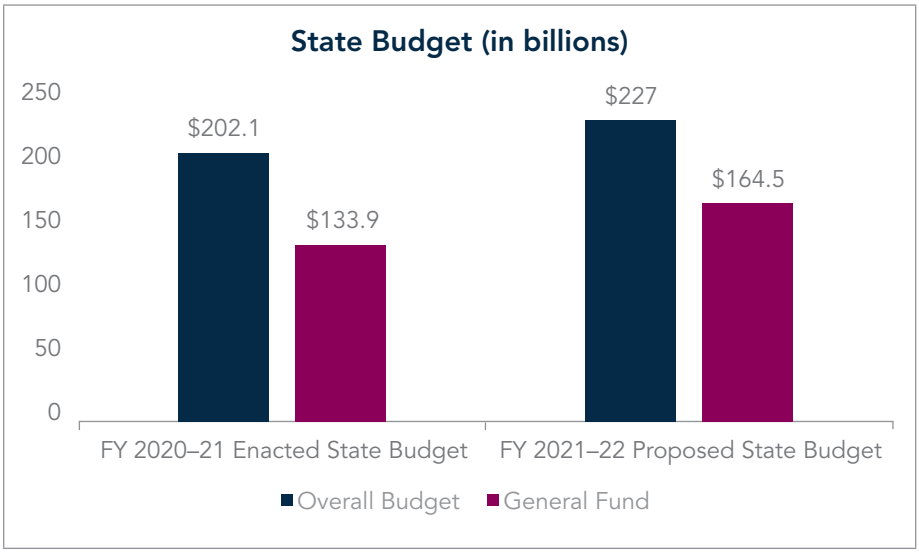
Overview

On January 8, 2021, Governor Gavin Newsom released the Fiscal Year (FY) 2021-22 Proposed State Budget. The total proposed budget is $227 billion, including $164.5 billion General Fund (GF). When compared to the 2020-21 Enacted Budget ($202.1 billion, including $133.9 billion GF), this reflects an increase in state spending of nearly 12 percent.[1]

Table 1. California State Budget



Proposed State Budget

After experiencing a $54 billion budget shortfall in the Enacted FY 2020-21 State Budget, the proposed budget estimates $34 billion in budget resiliency, including a $12 billion surplus and $22 billion in budget reserves. As the State continues to respond to the public health emergency, Governor Newsom's proposed budget expands upon existing health care programs while reintroducing proposals that were delayed due to last year's budget restraints and the COVID-19 pandemic. This memo includes highlights from the proposed budget, such as the return of the California Advancing and Innovating Medi-Cal (CalAIM) proposal and advancing the Master Plan for Aging (MPA), while continuing to respond to the COVID-19 pandemic.

Medi-Cal Budget

The Medi-Cal caseload is expected to increase by 1.5 million new beneficiaries to approximately 16.1 million total Medi-Cal beneficiaries by 2022.[2] This is due to the suspension of Medi-Cal eligibility redeterminations and the COVID-19 driven recession. To prepare for this increase, the budget proposes $122.2 billion ($28.4 billion GF). When compared to Medi-Cal funding in the FY 2020-21 Enacted Budget ($115.4 billion ($22.3 billion GF)), this represents an increase of nearly 6 percent.

Of note, several optional Medi-Cal funded benefits that were scheduled for suspension in 2021 have been delayed to expire no sooner than January 1, 2022, pending GF revenue in the subsequent two fiscal years.[3] In addition to Proposition 56 directed payments, In-Home Support Services (IHSS), and adult dental benefits, the proposed budget maintains funding for the following optional benefits:

Table 2. Optional Benefits

Optional Benefits
• Community-Based Adult Services; • Multipurpose Senior Services Program; • Podiatry • Acupuncture; • Optometry; • Nurse anesthetist services; • Audiology; • Incontinence creams and washes; • Speech therapy; • Optician/optical lab; • Occupational and physical therapy; • Pharmacist-delivered services; • Screening, brief intervention and referral to treatments for opioids and other illicit drugs in Medi-Cal; • Diabetes prevention program services.

Response to COVID-19

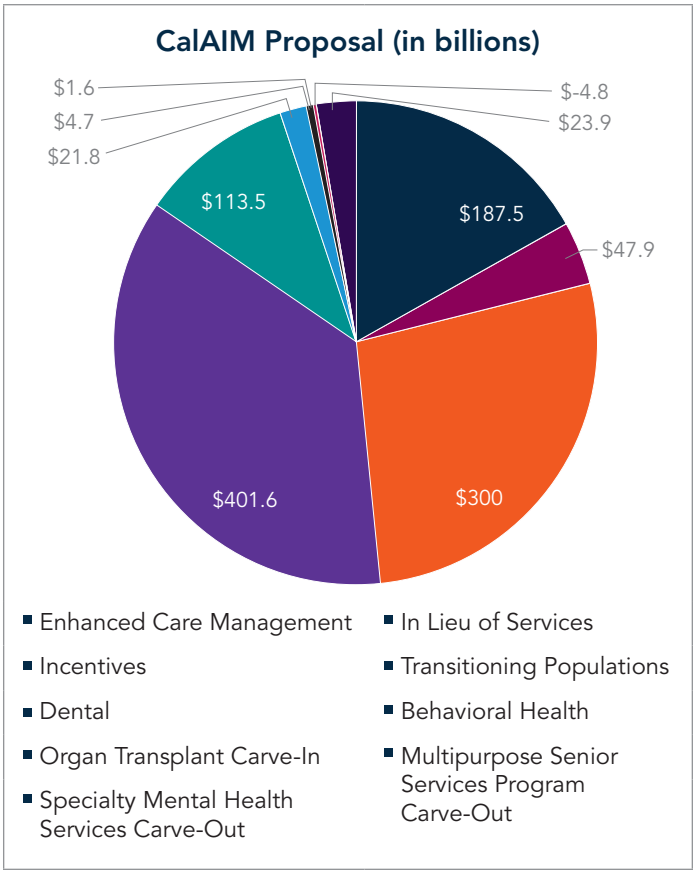
As of January 12, 2021, over 2.7 million Californians, including 196,300 residents from Orange County, have been diagnosed with COVID-19.[4] Under the authorities of the Emergency Services Act and other laws governing public health emergencies, the State continues to responds to the COVID-19 public health crisis. The proposed budget estimates a total spending cost of $13 billion ($2.5 billion GF), which includes costs in both 2020-21 and 2021-22. This includes one time GF spending of $4.4 billion to expand hospital capacity, vaccine distribution, COVID-19 testing and contact tracing, and securing personal protective equipment.[5] Of note, the budget does not yet account for the estimated $100 billion in additional federal funding that will be available through the most recent federal stimulus passed in December 2020.

CalAIM

The ambitious proposal, know as CalAIM, was suspended early in 2020 due to the COVID-19 pandemic. Recognizing the need to further efforts of coordinated care for Medi-Cal beneficiaries, Governor Newsom announced CalAIM's return with a proposed budget of $1.1 billion ($531.9 million GF) in FY 2021-22, growing to $1.5 billion ($755.5 million GF) in FY 2023-24.[6] The revised CalAIM proposal, effective no sooner than January 1, 2022, focuses on transforming the Medi-Cal program, targeting those with complex health needs, addressing high health care costs, and payment reform. CalAIM continues efforts relating to Enhanced Care Management (ECM), In Lieu of Services (ILOS), Social Determinants of Health, Behavioral Health, and Full Integration.

Together, these CalAIM proposals offer solutions designed to ensure the stability of the Medi-Cal program and allow the critical successes of waiver demonstrations, such as Whole Person Care Pilots, the Health Homes Program, and the Coordinated Care Initiative, which advance the coordination and delivery of quality care, to continue and be expanded to all Medi-Cal enrollees. Of note, CalOptima staff are collaborating with the Orange County Health Care Agency to reestablish a workgroup as the State begins the transition of Whole Person Care into ECM and ILOS.

Table 3. CalAIM Proposed Funding[7]



Behavioral Health for Youth

In addition to the full integration of Behavioral Health Services being proposed through CalAIM, the State recognizes the impacts that COVID-19 has had on the state's youth population. Distance learning, social isolation, and loss have resulted in an increase in behavioral health (BH) services. In response, Governor Newsom proposes one-time funding of $400 million to increase behavioral health services for children and students. This includes implementing an incentive plan through Medi-Cal managed care plans, in partnership with county BH departments, to increase the number of students receiving preventative and early intervention BH services by schools and Adverse Childhood Experiences (ACEs) screenings.[8]

Homelessness

California has the largest number of individuals experiencing homelessness in the nation, with more than 151,000 individuals living on the streets and in shelters.[9] The proposed budget builds upon existing efforts to end homelessness, such as Project Homekey, by allocating one-time funding of $1.75 billion GF to purchase additional motels, develop short-term community mental health facilities, and purchase or preserve housing dedicated to seniors.[10] The proposed budget also includes one-time funding of $750 million, over the course of three years, for the Department of Health Care Services (DHCS) to provide competitive grants to counties for the acquisition and rehabilitation of real estate assets to expand the community continuum of BH treatment resources. Overall, the FY 2021-22 Proposed State Budget includes more than $2 billion in homelessness resources and $8 billion in housing resources.[11]

2021–22 Homeless Funding
(Dollars in Millions)

Department	Program	Amount
Department of Housing and Community Development	Continued Homekey Acquisitions	$750.0
	Federal Funded Programs for Homelessness	$43.0
	Transitional Housing Program	$8.0
Office of Emergency Services	Various Homeless Youth Programs	$1.0
	Youth Emergency Telephone Network	$0.6
Department of Social Services	Expanded Facilities to Support Housing	$250.0
	CalWORKS Homeless Assistance Program	$38.5
	Housing and Disability Advocacy Program	$25.0
Department of Health Care Services	Behavioral Health Continuum Infrastructure	$750.0
	Project for Assistance in the Transition from Homelessness	$8.8
Department of Transportation	Homeless Encampment Cleanup on the State Highway System	$12.4
California Community Colleges	Basic Needs Funding - Student Hunger and Homelessness Programs	$100.0
	Rapid Rehousing	$9.0
California State University	Basic Needs Funding - Student Hunger and Homelessness Programs	$15.0
	Rapid Rehousing	$6.5
University of California	Basic Needs Funding - Student Hunger and Homelessness Programs	$15.0
	Rapid Rehousing	$3.5
Total		**$2,036.3**

2021–22 Affordable Housing Funding
(Dollars in Millions)

Department	Program	Amount
Department of Housing and Community Development	Veterans and Affordable Housing Bond Act Programs (Prop 1)	$490.0
	No Place Like Home	$400
	Building Homes and Jobs Fund Programs (SB 2)	$277.0
	Infill Infrastructure Grant Program Economic Recovery Investment	$500.0
	Federal Funded Programs for Housing	$78.6
	Verterans Housing and Homelessness Prevention	$5.0
	Various	$17.0
California Housing Finance Agency	Single Family First Mortgage	$3,000.0
	Multifamily Conduit Lending	$1,200.0
	Multifamily Permanent Lending	$410.0
	Mixed-Income Loan Program	$40.0
	Single Family Down Payment Assistance	$95.0
	Special Needs Housing Program	$15.0
Tax Credit Allocation Committee	Low Income Housing Tax Credits (State)	$602.7
	Low Income Housing Tax Credits (Federal)	$330.9
	Farmworker Housing Assistance Tax Credits	$4.2
Strategic Growth Council	Affordable Housing and Sustainable Communities	$426.0
Department of Veterans Affairs	CalVet Farm and Home Loan Program (Prop 1)	$170.0
Office of Emergency Services	Domestic Violence Housing First Program	$23.0
	Transitional Housing Program	$18.0
	Specialized Emergency Housing	$10.0
	Domestic Violence Assistance, Equality in Prevention and Services, Human Trafficking Victim Assistance, North American Domestic Violence and Sexual Assult	-
California Department of Corrections and Rehanilitation	Specialized Treatment of Optimized Programing, Parolee Service Center, Day Reporting Center, Female Offender Treatment and Employment Program, Proposition 47 Grant Program	-
Department of Social Services	CalWORKS Housing Support Program	$95.0
	CalWORKS Family Stabilization, Housng Component	$6.4
Department of Public Health	Housing Opportunities for Persons with AIDS (HOPWA)	$5.0
	Housing Plus Program	$1.0
	HIV Care Program	-
Total		**$8,289.8**

Telehealth

On March 16, 2020, in response to the COVID-19 pandemic, DHCS prioritized access to telehealth services to ensure providers are able to deliver medically necessary health care services in a timely fashion for beneficiaries impacted by COVID-19.[12] The Governor's proposed budget seeks to expand and make permanent certain telehealth flexibilities authorized during the COVID-19 pandemic for Medi-Cal providers by allocating $94.8 million ($34 million GF).[13] Furthermore, this item will add remote monitoring as a new covered Medi-Cal benefit effective January 1, 2022.

Medi-Cal Rx

The proposed budget accounts for the delayed implementation of Medi-Cal Rx carve-out until April 1, 2021, and includes the following estimates:

- Costs in 2020-21: $219.9 million ($70.2 million GF), which are temporary net costs due to implementation delay;
- Estimated Savings in 2021-22: $612.7 million ($238.2 million GF); and
- Estimated Annual Savings by 2023-24: $1.2 billion ($419 million GF).[14]

Master Plan for Aging

The proposed budget recognizes the challenges that older Californians and their families face during the pandemic and proposes a range of investments to increase opportunities for California's older adult populations. This includes proposals, such as the Master Plan for Aging (MPA), a statewide blueprint to promote and support successful aging, develop new strategies, and leverage the Medicare program to provide additional long-term services and supports. This includes $5 million to support the MPA, implemented by the California Health and Human Services Agency (CHHS).[15]

Health Equity

The COVID-19 pandemic has exposed long-standing health inequities seen among people of color. Additionally, the pandemic has highlighted social, economic, and health inequities contributing to the disproportionately higher infection and mortality rates for those with chronic and infectious diseases. The proposed budget seeks to address issues related to health equity by allocating $9.4 million ($8.6 million GF). This includes $5.3 million ($3.2 million GF) for the Department of Developmental Services to contract with family resource centers to implement a navigator model statewide and $1.7 million GF to analyze the impacts of COVID-19 on diverse populations.[16]

Managed Care Capitation Corrections

There is an estimated net cost of $300 million to run and process payments based on what is known as an "extended file" in CAPMAN to process enrollments and disenrollments in CAPMAN back to January 2014. Once completed and verified, the file will be processed through the CAPMAN system. This will create a corrected file reflecting the proper enrollments and disenrollments from January 2014 up to the current calendar year, thus resulting in either a recoupment or pay out of the appropriate plan funds for the identified beneficiaries.[17]

Other Medi-Cal Proposals

With a strong Medi-Cal budget, Governor Newsom proposed two additional benefits for the Medi-Cal program:

- Include Continuous Glucose Monitors as a Medi-Cal covered benefit by allocating $10.9 million ($3.8 million GF), effective January 1, 2022[18]; and
- Extend restoration of adult over-the-counter (OTC) cough/cold drugs and acetaminophen. This would result in an annual savings of $21 million ($7.8 million GF) to continue these OTC drugs as covered Medi-Cal benefits beyond COVID-19 waiver flexibilities.[19]

Next Steps

The Governor's January budget proposal is only the first step in the state's budget process. Many of these proposals, such as CalAIM, will require additional legislation to implement. The legislature will hold policy and budget hearings in an effort to build consensus on these proposals. CalOptima will continue to closely follow these ongoing budget discussions and provide updates regarding any issues that support the advancement of CalOptima's legislative priorities.

About CalOptima

CalOptima, a county organized health system (COHS), is the single plan providing guaranteed access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

If you have any questions regarding the above information, please contact:

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Endnotes

[1] 2021-22 Governor's Budget: Proposed Budget Detail, January 8, 2021
[2] Department of Health Care Services, 2021-22 Governor's Budget, January 8, 2021, Pg. 4
[3] 2021-22 Governor's Budget Summary, January 8, 2021, Pg. 107
[4] California COVID-19 State Dashboard
[5] 2021-22 Governor's Budget Summary, January 8, 2021, Pg. 46
[6] 2021-22 Governor's Budget Summary, January 8, 2021, Pg. 105
[7] Department of Health Care Services, 2021-22 Governor's Budget, January 8, 2021, Pg. 6
[8] 2021-22 Governor's Budget Summary, January 8, 2021, Pg. 71
[9] Center for Health Care Strategies: California Health Care and Homelessness Learning Community, September 2020
[10] 2021-22 Governor's Budget Summary, January 8, 2021, Pg. 131
[11] 2021-22 Governor's Budget Summary, January 8, 2021, Pg. 133
[12] Department of Health Care Services, Medi-Cal Payment for Medical Services Related to the 2019-Novel Coronavirus (COVID-19), March 16, 2020
[13] 2021-22 Governor's Budget Summary, January 8, 2021, Pg. 106
[14] 2021-22 Governor's Budget Summary, January 8, 2021, Pg. 106
[15] Department of Health Care Services, 2021-22 Governor's Budget, January 8, 2021, Pg. 8
[16] 2021-22 Governor's Budget Summary, January 8, 2021, Pg. 98
[17] Department of Health Care Services, 2021-22 Governor's Budget, January 8, 2021, Pg. 9
[18] Department of Health Care Services, 2021-22 Governor's Budget, January 8, 2021, Pg. 13
[19] 2021-22 Governor's Budget Summary, January 8, 2021, Pg. 106

Legislative Update: California Advancing and Innovating Medi-Cal (CalAIM)

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Overview

The ambitious proposal, known as California Advancing and Innovating Medi-Cal (CalAIM), was suspended in early 2020 due to the COVID-19 pandemic. Recognizing the need to further efforts of coordinated care for Medi-Cal beneficiaries, on January 8, 2021, Governor Newsom announced CalAIM's return with a proposed budget of $1.1 billion ($531.9 million General Fund) in FY 2021–22, growing to $1.5 billion ($755.5 million GF) in FY 2023–24. The revised CalAIM proposal, effective no sooner than January 1, 2022, focuses on transforming the Medi-Cal program, targeting those with complex health needs, addressing high health care costs, and implementing payment reform. This memo includes a high-level overview of segments within the CalAIM proposal that may have a direct impact on CalOptima.

CalAIM

Population Health Management

The Population Health Management (PHM) program seeks to improve overall health outcomes and efficiency of care management by assessing individual member health risks and by creating wellness, prevention, case management and care transition programs. All Medi-Cal managed care plans (MCPs) shall develop and maintain a whole system, person-centered PHM program, where the plan will partner with contracted health care providers and community-based partners to identify and address members' health and health-related social needs. Within the PHM program, the following CalAIM elements will help magnify the anticipated positive impact the program has on member outcomes:

- National Committee for Quality Assurance (NCQA) Accreditation
- Enhanced Care Management
- In Lieu of Services
- Shared Risk Savings and Incentive Payments[2]

Timeline: Effective no sooner than January 1, 2023.

Enhanced Care Management

The Department of Health Care Services (DHCS) proposed the implementation of a single, comprehensive Enhanced Care Management (ECM) benefit within Medi-Cal managed care. The ECM proposal replaces the current Health Homes Program (HHP) and Whole Person Care (WPC) pilot program by merging them into one comprehensive program. The overarching goals of ECM are:

- Improving care coordination
- Integrating services
- Facilitating community resources
- Improving health outcomes
- Addressing social determinants of health
- Decreasing inappropriate utilization

Additionally, the ECM proposal suggests the following populations be eligible to receive ECM services:

- Children or youth with complex physical, behavioral, developmental and/or oral health needs
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays or emergency room visits
- Individuals at risk for institutionalization who are eligible for long-term care services
- Nursing facility residents who want to transition to the community
- Individuals at risk for institutionalization with Serious Mental Illness, children with Serious Emotional Disturbance or Substance Use Disorder with co-occurring chronic health conditions
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community[3]

Timeline: Medi-Cal MCPs currently operating an HHP *or* operating in a county with a WPC pilot are required to submit a transition and coordination plan to DHCS by July 1, 2021. Those Medi-Cal MCPs will then be required to implement ECM on January 1, 2022. Draft contract provisions will be shared with plans in February 2021.

In Lieu of Services

CalAIM also builds upon WPC and HHP programs through In Lieu of Services (ILOS). According to federal Medicaid programs rules, ILOS are medically appropriate and cost-effective alternatives to services that can be covered under the State Plan. If approved, ILOS will operate in conjunction with PHM and ECM in order to focus on addressing combined medical and social determinants of health needs to avoid higher levels of care. Furthermore, DHCS proposed to include 14 distinct services as ILOS under Medi-Cal managed care:

In Lieu of Services Options

- Housing transition/navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Short-term post-hospitalization housing
- Recuperative care
- Respite services
- Day habilitation programs
- Nursing facility transition/diversion to assisted living facilities
- Community transition services/nursing facility transition to a home
- Personal care and homemaker services
- Environmental accessibility adaptations
- Meals/medically tailored meals
- Sobering centers
- Asthma remediation

Each service will have defined eligible populations, code sets, potential providers, restrictions and limitations. Additionally, the provision of ILOS is voluntary for Medi-Cal MCPs, and beneficiaries have to option to accept or decline ILOS. Of note, CalOptima staff are collaborating with community stakeholders to gather data and provide recommendations on which ILOS options CalOptima should provide.

Timeline: Medi-Cal MCPs currently operating an HHP and WPC pilot program are required to submit a transition and coordination plan to DHCS by July 1, 2021. Those Medi-Cal MCPs will then be required to implement ILOS on January 1, 2022.[4]

Shared Risk, Shared Savings and Incentive Payments

The proposal to combine PHM, ECM and ILOS, in addition to Long-Term Care, provides an opportunity to encourage MCPs and providers to be fully engaged in these CalAIM proposals. Therefore, DHCS proposed to create a series of incentives through a multipronged risk strategy. Potential incentives include:

- A blended capitation rate to account for the addition of seniors and persons with disabilities and long-term care beneficiaries into managed care
- A time-limited, tiered and retrospective shared savings/risk financial calculation performed by DHCS
- A prospective payment model of shared risk or shared savings incorporated via capitation rate development[5]

Timeline: DHCS will engage and collaborate with Medi-Cal MCPs and make future refinements as determined appropriate.

- January–December 2021: Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input.
- January 1, 2022: Begin implementation of managed care plan incentives.
- No sooner than January 1, 2023: Begin implementation of a seniors and persons with disabilities/long-term care blended rate.

Full Integration Plans

Currently, Medi-Cal beneficiaries are required to navigate several managed care and fee-for-service Medi-Cal systems to receive comprehensive care. DHCS proposed the full integration of physical health, behavioral health and oral health under one contracted entity: DHCS. This requires multiple Medi-Cal delivery systems, including Medi-Cal managed care, county mental health plans, county Drug Medi-Cal and Drug Medi-Cal Organized Delivery System programs, to be consolidated under one contract with DHCS.[6]

Timeline: No sooner than January 2026.

Long-Term Plan for Foster Care

DHCS is exploring the option of a single, statewide managed care plan for foster youth. Under the Medi-Cal program, beneficiaries receive services through various delivery systems, including Medi-Cal managed care, fee-for-service, California Children's Services, regional centers, county mental health plans and Drug Medi-Cal programs. However, many challenges remain in navigating Medi-Cal delivery systems, especially if there are multiple placements that may result in the child moving from one county to another or between homes in a single county. In June 2020, DHCS reconvened a stakeholder workgroup to consider this proposal.[7]

Timeline: Pending stakeholder engagement and feedback and state budget recommendations.

Managed Care Benefit Standardization

Under CalAIM, DHCS proposed to standardize benefits that are provided through Medi-Cal MCPs statewide, regardless of the beneficiary's county of residence or the plan they are enrolled in. This supports CalAIM's goal for a regional standardized set of benefits delivered by MCPs, no matter which county the beneficiary resides in. Therefore, CalAIM proposed four changes to the Medi-Cal program, including the highly anticipated pharmacy carve-out, by carving in and carving out specific covered benefits.

Carved-Out Benefits: Managed by DHCS

Program	Timeline
Pharmacy benefits	No sooner than April 1, 2021
Multipurpose Senior Services Program (MSSP)	January 1, 2022

Carved-In Benefits: Managed by the MCP

Program	Timeline
Major organ transplants	January 1, 2022
Long-term care (LTC) services*	January 1, 2023

*LTC services are already managed by CalOptima and propose no major operational changes.

Of note, the managed care benefit standardization proposal paves a path for the state to propose regional rate setting.[8]

Timeline: By January 1, 2023.

Mandatory Managed Care Enrollment

Medi-Cal beneficiaries currently receive coverage either through fee-for-service or managed care. To increase enrollment into managed care, DHCS proposed to standardize which aid code groups require mandatory managed care enrollment versus fee-for-service, statewide. This would require Medi-Cal beneficiaries to choose a Medi-Cal MCP, and they would no longer be permitted to remain in fee-for-service. Mandatory enrollment from fee-for-service into an MCP affects populations such as individuals participating in accelerated enrollment, pregnancy-related Medi-Cal and American Indians, to name a few.[9]

Timeline: DHCS proposed a two-phase implementation timeline, transitioning non-dual eligible populations on January 1, 2022, and dual eligible populations on January 1, 2023.

Transition to Statewide Long-Term Services and Supports, Long-Term Care, and Dual Eligible Special Needs Plans

Returning to the CalAIM proposal is the transition of Cal MediConnect (CMC) and the Coordinated Care Initiative (CCI) to a statewide Managed Long-Term Services and Supports (MLTSS) and Dual Eligible Special Needs Plan (D-SNP) structure. This CalAIM proposal leverages best practices from the seven counties that implemented CMC and CCI, including Orange County, to develop policies and to promote integrated care thorough D-SNPs and MLTSS across the state. Of note, when CalOptima joined the CMC and CCI programs, CalOptima's D-SNP, OneCare, continued as one of CalOptima's lines of

business. Therefore, CalOptima will not have to reinstate the program.[10]

Timeline: All existing D-SNPs had to meet new regulatory integration standards by January 1, 2021, to support the following timeline scheduled to take place over the next six years:

Implementation Date	Operational Changes
January 1, 2022	• Voluntary ILOS in all MCPs and CMC plans • MSSP carved out of MCPs in CCI counties
December 31, 2022	• Discontinue CMC and CCI
January 1, 2023	• Statewide mandatory enrollment of full- and partial-benefit dual eligible beneficiaries into MCPs for Medi-Cal benefits, including dual and non-dual eligible LTC residents • Statewide integration of LTC • Aligned enrollment begins in CCI counties • All CMC members cross-walked to matching D-SNPs and MCPs
January 1, 2025	• Aligned enrollment begins in CCI counties • All MCPs required to operate D-SNPs
January 1, 2027	• Implement MLTSS statewide in Medi-Cal managed care

NCQA Accreditation of Medi-Cal Managed Care Plans

The NCQA is a private, nonprofit organization that offers accreditation to health plans and other health care-related entities in the areas of quality improvement, PHM, network management, utilization management, credentialing and recredentialing, and member experience. To streamline MCP oversight and to increase standardization across plans, DHCS recommended requiring all Medi-Cal MCPs and their subcontractors to be NCQA accredited. Of note, at this time, DHCS is not requiring that MCPs ensure any non-health plan subcontractors to whom certain contractual elements are delegated are NCQA accredited for that specific function.[11]

Timeline: January 1, 2026

Regional Managed Care Capitation Rates

Currently, DHCS develops managed care capitation rates for each contracted MCP based on county, region and population. To reduce the number of distinct rating components DHCS develops on an annual basis, and as a way to incentivize MCPs to operate efficiently, DHCS proposed a regional rate setting methodology.[12]

Timeline: No sooner than January 1, 2024, to fully implement regional rates statewide.

Behavioral Health: Medical Necessity Criteria

CalAIM seeks to improve access to medically necessary behavioral health (BH) services by ensuring the beneficiary receives the right care in the right place and at the right time. DHCS proposed the following actions to address beneficiaries' needs across the continuum of care:

- Update and clarify the medical necessity criteria for specialty mental health services for both adults and children
- Clarify the Early and Periodic Screenings, Diagnosis and Treatment (EPSDT) protections for beneficiaries under the age of 21, and create criteria for children to access specialty mental health services
- Develop a standardized screening tool to facilitate accurate determinations of when care would be better delivered in the specialty mental health delivery system or in the Medi-Cal managed care/fee-for-service system
- Implement a "no wrong door" policy
- Simplify and streamline mental health documentation requirements
- Update the criteria for psychiatric inpatient and medical necessity currently provided in Title 9 of the California Code of Regulations
- Modify the current Section 1115 waiver to allow Substance Use Disorder treatment services to be provided and be reimbursed prior to the determination of a diagnosis
- Update overall medical necessity criteria and processes[13]

Of note, BH care and services shall be coordinated between the specialty mental health plan and the Medi-Cal MCP, and services shall not be duplicated.

Timeline: January 1, 2022, with the approval of the Section 1115 and 1915(b) waivers.

Enhancing County Oversight and Monitoring: California Children's Services and Child Health Disability Prevention

As of July 1, 2019, CalOptima members' needs related to California Children's Services (CCS) became a part of CalOptima's Medi-Cal plan. Within the CalAIM proposal, DHCS intends to provide enhanced monitoring and oversight of all 58 counties and three cities (Berkeley, Pasadena and Long Beach) to ensure continuous optimal care for children.[14]

Timeline: The proposal includes a phased timeline approach.

Phase: Date	Action
Phase I: August 2020–June 2021	• Review of current standards, policies and guidelines • Development of goals, performance measures and metrics • Revision of current Plan and Fiscal Guidelines guidance document • Continuation of the establishment of an electronic submission portal for the annual county/city budgets
Phase II: July–September 2021	• Development of auditing tools
Phase III: October 2021–September 2022	• Shift to an electronic automated submission by the counties/cities • Develop training documents • Evaluate and analyze findings and trends • Identify gaps and vulnerabilities
Phase IV: October 2022–Ongoing	• Initiate Memorandum of Understanding between state and counties • Continuous monitoring and oversight • Continuous updates to standards, policies and guidelines

Next Steps

Although the CalAIM proposal is included in the governor's proposed budget, this is only the first step in the state's legislative process. Many of the proposals within CalAIM will require additional stakeholder engagement, legislation and trailer bill language over several years in order to implement. CalOptima will continue to closely follow these ongoing CalAIM discussions and provide updates regarding any issues that support the advancement of CalOptima's legislative priorities. Additionally, CalOptima will work collaboratively with our provider, member, county and community stakeholders to better understand the impact of the proposed CalAIM initiatives as we move forward with implementation.

About CalOptima

CalOptima, a county organized health system (COHS), is the single plan providing guaranteed access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

If you have any questions regarding the above information, please contact:

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Endnotes

[1] 2021-22 Governor's Budget Summary, January 8, 2021, Pg. 105
[2] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 43
[3] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 45
[4] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 54
[5] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 57
[6] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 61
[7] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 62
[8] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 65
[9] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 67
[10] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 70-73
[11] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 74
[12] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 76
[13] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 82
[14] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 105

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CalOptima

Better. Together.

COVID-19 Update

Board of Directors Meeting
February 4, 2021

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

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COVID-19 Efforts in Progress

- County Vaccine Survey
- Member Incentive Implementation
- Member Vaccination Strategy
- Communications Strategy
- COVID-19 Items for Board Consideration
  - Report Items 18-22

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CalOptima
A Public Agency

COVID-19 Communications Strategy

- Awareness campaign launching February 2021
  - Print, outdoor, radio, digital and social media, social media, direct mail, virtual events
- Collateral materials
  - Member FAQs and newsletters, provider FAQs and updates
- Community outreach
  - Panel discussions and town halls
- Media pitching
  - Newspapers, TV, radio and op-ed

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CalOptima
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Our Mission

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

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CalOptima
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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

December 3, 2020

A Regular Meeting of the CalOptima Board of Directors was held on December 3, 2020, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act. Chair Andrew Do called the meeting to order at 2:01 p.m. and Director Schoeffel led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chair; Clayton Chau (non-voting) (at 2:08 p.m.); Clayton Corwin; Mary Giammona, M.D.; Victor Jordan; Scott Schoeffel; Trieu Tran, M.D.
(Director Chau, Director Corwin, Director Giammona, and Director Schoeffel participated remotely)

Members Absent: Isabel Becerra, Vice Chair; Supervisor Steel

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

PRESENTATIONS/INTRODUCTIONS

None.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Richard Sanchez, Chief Executive Officer, highlighted several items from his report, which included an update on the delay of the Medi-Cal Pharmacy Carve-Out (Medi-Cal Rx) transition. Mr. Sanchez also covered Agenda Item 2, the COVID-19 Update. He noted that this is a fast-moving situation and encouraged everyone to wear a mask. Mr. Sanchez reported that CalOptima is working closely with the Orange County Health Care Agency on the Vaccine Taskforce. Mr. Sanchez reported that $13.2 million was awarded to enhance mental health services in Orange County through the state's Behavioral Health Integration Incentive Program, noting that all 12 of the proposals CalOptima submitted were awarded funding. Mr. Sanchez also reported that CalOptima was selected to participate in the new Homelessness Learning Collaborative.

Director Chau commented on Governor Newsom's new Regional Stay at Home Order, which applies regionally, rather than at the county level, as COVID-19 cases continue to rise. Orange County is part of the Southern California Region. If the Regional Stay at Home is triggered, the region will be in lock down for a minimum of three weeks.

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Chairman Do directed staff to continue work on developing a plan to address the various issues that COVID-19 has caused for CalOptima's members. Chairman Do noted that developing a plan that factors in wraparound services will help prevent overwhelming the health care delivery system and better align CalOptima with other providers of services in the Orange County community.

Chairman Do announced the formation of an ad hoc committee to review the legal structure at CalOptima. He appointed himself, Director Schoeffel, and Director Giammona to the ad hoc. Chairman Do noted that the ad hoc will work with CEO Sanchez, and Chief Counsel Gary Crockett.

2. COVID-19 Update
Update was covered under Agenda Item 1, Chief Executive Officer Report.

PUBLIC COMMENTS

1. Jenny Truong – Oral re: Congregate Living Health Facility (CLHF) contracting.
2. Mark Costa, Senior Vice President, Kaiser Permanente Orange County – Oral re: Agenda Item 16. "Consider Authorizing an Amended and Restated Health Network Contract for Kaiser Foundation Health Plan Inc. and Amendments Incorporating Operational Provisions and Revised Capitation Rates"

CONSENT CALENDAR

3. Minutes
   a. Approve Minutes of the November 5, 2020 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the September 17, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; the Minutes of August 13, 2020 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee; the Minutes of the September 10, 2020 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee; and the Minutes of the October 8, 2020 Joint Meeting of the CalOptima Board of Directors' Member Advisory, OneCare Connect Member Advisory, the Provider Advisory, and the Whole-Child Model Family Advisory Committees

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

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

6. Consider Authorizing an Amendment to the Amended and Restated Development Agreement with the City of Orange to Extend CalOptima's Development Rights
Director Schoeffel did not participate in this item due to potential conflicts of interest.

7. Consider Approval of Proposed Revisions to CalOptima's Operations Policies and Procedures

8. Consider Authorization of the Reallocation of Budgeted but Unspent Salary Dollars to Expand the Scope of Work of a Contract for External Peer Review Services Contract and Extend a Contract for Medical Consulting Services
Director Schoeffel did not participate in this item due to potential conflicts of interest.

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9. Consider Approval of Actions Authorizing Extensions and Other Modifications of Whole Person Care Agreements with the Orange County Health Care Agency
Director Schoeffel did not participate in this item due to potential conflicts of interest. Dr. Chau did not participate in this item due to his role at the Director of the Orange County Health Care Agency.

10. Consider Authorization of Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2020–2021 Capital Budget
Director Schoeffel did not participate in this item due to potential conflicts of interest.

11. Consider Ratifying Contract with Chapman Consulting for Consulting Services related to the 2020-2022 Strategic Plan
Director Schoeffel did not participate in this item due to potential conflicts of interest.

12. Consider Approval of Modifications to Policy GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N

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

14. Consider a New Letter of Commitment for Medi-Cal Supportive Services in Connection with a Grant Award to American Family Housing under the Housing for a Healthy California Program
This item was pulled for a separate vote. Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act.

15. Receive and File

Rev. 12/3/20

a. October ~~September~~ 2020 Financial Summary
b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Community Outreach and Program Summary

Staff noted a correction to Agenda Item 15.a. that references September 2020 Financial Summary and should be October 2020 Financial Summary.

Director Schoeffel did not participate in Consent Calendar Agenda Items 6, 8, 9, 10, and 11 due to potential conflicts.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors approved Consent Calendar Items 3 through 15, minus Consent Calendar Item 14, with the correction noted for Consent Calendar Agenda Item 15.a., as presented. (Motion carried 6-0-0 except as noted; Vice Chair Becerra; Supervisor Steel absent)***

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors withdrew the approval Consent Calendar Items 3 through 15, minus Consent Calendar Item 14, with the correction noted for Consent Calendar***

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Item 15a, as presented. (Motion carried 6-0-0 except as noted; Vice Chair Becerra; Supervisor Steel absent)

Action: ***On motion of Director Tran, seconded and carried, the Board of Directors approved Consent Calendar Items 3 through 15, minus Consent Calendar Item 14, with the correction noted for Consent Calendar Item 15a, as presented. (Motion carried 6-0-0 except as noted; Vice Chair Becerra; Supervisor Steel absent)***

14. Consider a New Letter of Commitment for Medi-Cal Supportive Services in Connection with a Grant Award to American Family Housing under the Housing for a Healthy California Program
This item was pulled for a separate vote. Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest based on campaign contributions under the Levine Act.

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors approved Consent Calendar Item 14, as presented. (Motion carried 5-0-1; Chairman Do abstained; Vice Chair Becerra; Supervisor Steel absent)***

REPORTS

16. Consider Authorizing an Amended and Restated Health Network Contract for Kaiser Foundation Health Plan Inc. and Amendments Incorporating Operational Provisions and Revised Capitation Rates
Director Schoeffel did not participate in this item due to potential conflicts of interest.

Mr. Sanchez, noted that much progress has been made and with Kaiser's commitment to work on finalizing the contract, suggested that the Board amend the motion to extend the current term of the contract through the date of the next Regular CalOptima Board meeting, February 4, 2021.

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors authorized the amended motion to authorize an amendment to the current Kaiser Foundation Health Plan, Inc. Health Network Contract to extend the current term through the date of the next Regular CalOptima Board meeting, February 4, 2021. (Motion carried 5-0-0; Vice Chair Becerra; Director Schoeffel; Supervisor Steel absent)***

17. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Change the Effective Date Removing the Medi-Cal Line of Business
Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima's Pharmacy Benefits Manager (PBM) services agreement with MedImpact Healthcare Systems Inc. (MedImpact) to remove Medi-Cal PBM services under the contract effective on the date that the Department of Healthcare Services (DHCS) takes over Medi-Cal Managed***

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Care pharmacy benefits, which is expected to be no earlier than April 1, 2021. (Motion carried 5-0-0; Vice Chair Becerra; Director Schoeffel; Supervisor Steel absent)

18. Consider Authorizing Amendments to the Medi-Cal Shared-Risk Physician Group, Physician Hospital Consortium, and Health Maintenance Organization Health Network Contracts, Except Kaiser Foundation Health Plan, Inc.

This item was continued to a future meeting due to lack of a quorum. Acting Chair Giammona noted that staff may bring this item back to the next meeting with a request for ratification.

REPORTS

19. Consider Approval of Modification to CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors: Approve modifications to CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting [Medi-Cal, OneCare, OneCare Connect]. (Motion carried 6-0-0; Vice Chair Becerra; Supervisor Steel absent)***

20. Consider Approval of Actions Related to Homeless Health Care Pilot Initiatives

Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors, regarding the Clinical Field Team Pilot Program (CFTPP) and Homeless Health Initiative (HHI) FQHC Expansion Pilot: 1.) Extended both pilots through December 31, 2021; and 2.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend contracts with Federally Qualified Health Centers (FQHCs) and FQHC Look-alikes providing services under CFTPP. (Motion carried 5-0-0; Vice Chair Becerra; Director Schoeffel; Supervisor Steel absent)***

21. Consider Authorizing Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2021

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

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors, authorized the following activities to secure Medi-Cal funds through the Voluntary Rate Range Intergovernmental Transfer for Calendar Year 2021 (IGT 11): 1.) Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in IGT 11; 2.) Pursuit of funding partnerships with the University of California-Irvine, First 5 Orange County Children & Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in IGT 11; and 3) Development and execution by the Chief Executive Officer, with the assistance of Legal***

Counsel, of agreements with these entities and their designated providers as necessary to seek IGT 11 funds. (Motion carried 5-0-0; Vice Chair Becerra; Director Schoeffel; Supervisor Steel absent)

22. Consider Authorizing Amendment to Ancillary Contract with the Illumination Foundation
Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors, authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima's contract with the Illumination Foundation to exercise the first of three one-year extension options, extending the contract agreement until December 31, 2021. (Motion carried 5-0-0; Vice Chair Becerra; Director Schoeffel; Supervisor Steel absent)***

Chairman Do noted that Agenda Items 23, 24, and 25 involve updates to CalOptima's Compliance Plan as well as updates to Finance and Human Resources policies, and unless Board members would like to hear staff presentations on these items, in the interest of time, suggested considering them in a single motion.

23. Consider Adoption of Resolution Approving Revised CalOptima 2021 Compliance Plan and Authorizing the Chief Executive Officer to Approve Revised Office of Compliance Policies and Procedures
Recommended actions for Agenda Items 23 through 25 were each read into the record and approved in one motion and vote.

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors, 1.) Adopted Resolution No. 20-1203-03, Approving Revised CalOptima 2021 Compliance Plan; and 2.) Authorized the Chief Executive Officer to Approve Revised Office of Compliance Policies and Procedures. (Motion carried 6-0-0; Vice Chair Becerra; Supervisor Steel absent)***

24. Consider Approval of Modifications to CalOptima Policy FF.1007: Health Network Reinsurance Coverage and FF.4000 Whole-Child Model – Financial Reimbursement for Capitated Health Networks

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors, authorized the Chief Executive Officer to Approve Revised Office of Compliance Policies and Procedures; Approved modifications to the following policies pursuant to CalOptima's annual policy review process: 1.) CalOptima Policy FF.1007: Health Network Reinsurance Coverage; and 2.) CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks. (Motion carried 6-0-0; Vice Chair Becerra; Supervisor Steel absent)***

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

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors, adopted Resolution Approving CalOptima's Updated Human Resources Policies: 1.) GA.8012: Conflicts of Interest; 2.) GA.8018: Paid Time Off; 3.) GA.8019: Promotions and Transfers; 4.) GA.8020: 9/80 Work Schedule; 5.) GA.8026: Employee Referral Program; and 6.) GA.8047: Reduction in Force. (Motion carried 6-0-0; Vice Chair Becerra; Supervisor Steel absent)***

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

Director Schoeffel made a motion to re-elect Chairman Do as Chair and re-elect Vice Chair Becerra as Vice Chair through CalOptima's fiscal year end on June 30, 2021.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors, elected Supervisor Andrew Do to serve as Board Chair and elected Isabel Becerra to serve as Board Vice Chair for terms commencing on January 1, 2021 and running through June 30, 2021, or until such time as a successor(s) elected unless he, she or they shall sooner resign or be removed from office. (Motion carried 6-0-0; Vice Chair Becerra; Supervisor Steel absent)***

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Giammona congratulated Chairman Do and Vice Chair Becerra and thanked them for their leadership. In addition, Director Giammona thanked Mr. Sanchez and staff for their work and assistance. Chairman Do thanked the Board members for their support and thanked Mr. Sanchez for his leadership.

ADVISORY COMMITTEE UPDATES

27. OneCare Connect Member Advisory Committee Update

Patty Mouton, Chair, OneCare Connect Member Advisory Committee (OCC MAC), provided an update on recent OCC MAC activities and noted there will be joint meeting of the committees in March 2021.

28. Whole-Child Model Family Advisory Committee Update

Kristen Rogers, Chair, Whole-Child Model Family Advisory Committee (WCM FAC), provided an update on recent WCM FAC activities.

29. Provider Advisory Committee Update

John Nishimoto, Vice Chair, Provider Advisory Committee (PAC), congratulated Chairman Do on his reappointment and provided an update on recent PAC activities.

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30. Member Advisory Committee Update

Christine Tolbert, Chair, Member Advisory Committee (MAC), thanked the Board for listening to the Committee Members' concerns throughout the year and also offered assistance to the Board regarding the current challenges with COVID-19 pandemic.

CLOSED SESSION

The Board of Directors adjourned to closed session at 3:38 p.m. pursuant to Government Code Section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. Long Beach Memorial Medical Center, et al. v. CalOptima et al. (Orange County Superior Court (OCSC) Case No. 30-2019-01046530-CU-CO-CJC) and pursuant to Government Code Section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. Long Beach Memorial Medical Center, et al. v. CalOptima et al. (OCSC Case No. 30-2020-01141526-CU-BC-CJC); and pursuant to Government Code Section 54956.8: CONFERENCE WITH REAL PROPERTY NEGOTIATORS Property: 13300 Garden Grove Blvd, Garden Grove, CA 92843
Agency Negotiators: Justin Hodgdon, David Kluth, and Mai Hu, Newmark Knight Frank
Negotiating Parties: Young S. Kim and Soon Y. Kim
Under Negotiation: Price and Terms of Payment

The Board reconvened to open session at 5:02 p.m. with no reportable action taken.

ADJOURNMENT

Hearing no further business, Chairman Do adjourned the meeting at 5:03 p.m.

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Sharon Dwiers
Clerk of the Board

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MINUTES

SPECIAL MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

January 7, 2021

A Special Meeting of the CalOptima Board of Directors was held on January 7, 2021, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act. Chair Andrew Do called the meeting to order at 2:03 p.m. and Director Giammona led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chair; Isabel Becerra, Vice Chair; Clayton Chau (non-voting) (left meeting at 3:30 p.m.); Clayton Corwin; Mary Giammona, M.D.; Victor Jordan; Scott Schoeffel (left meeting at 3:17 p.m.); Trieu Tran, M.D. (All Board Members participated remotely)

Others Present: Richard Sanchez, Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Chief Financial Officer; Sharon Dwiers, Clerk of the Board

PRESENTATIONS/INTRODUCTIONS

None.

PUBLIC COMMENTS

None.

Chairman Do noted that, similar to the situation in other parts of the state, the county, and the world, the coronavirus pandemic (COVID-19) is causing significant, pressing challenges in Orange County. As a result, we at CalOptima should anticipate many changes, including increased membership due to the economic hardship the pandemic is causing, as well as broader changes at local, state, and federal levels. He noted that the first item on today's agenda, the CalOptima 2020-2022 Strategic Plan Review Session, was originally scheduled to provide the Board members with an opportunity to hear about the current strategic plan and use the session as a starting point to provide input on the direction that CalOptima should focus on going forward. However, due to the need to attend to pressing matters caused by the pandemic, Chairman Do recommended that staff present the current Strategic Plan and delay the future direction discussion until a later date given the unprecedented times and immediate needs of the community.

MANAGEMENT REPORTS

1. CalOptima 2020-2022 Strategic Plan Review Session

Richard Sanchez, Chief Executive Officer, introduced CalOptima's new Executive Director of Public Affairs, Rachel Selleck.

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Ms. Selleck provided a brief overview of the of the Strategic Plan and introduced CalOptima's consultants, Athena Chapman of Chapman Consulting, and Caroline Davis of Davis Health Strategies LLC.

Ms. Chapman and Ms. Davis provided background on the strategic planning process the CalOptima Board took in 2019 and 2020 when the current Strategic Plan was developed, and on the overall health care environment at the time the current Strategic Plan was developed. They noted that many of the initiatives that had been included in the current Strategic Plan have changed substantially or been delayed due to the pandemic.

2. COVID-19 Update

Mr. Sanchez provided a brief overview of a number of CalOptima's COVID-19 response efforts, including implementing the state's long-term care, rate increases, and the 24/7 virtual urgent care pilot for Community Care Network (CCN) members. In addition, he noted that the CalOptima behavioral health line is now available 24/7. Mr. Sanchez also highlighted CalOptima's work with the Orange County Health Care Agency (OCHCA) on Project Homekey and other initiatives that are intended to expand services to members experiencing homelessness.

Emily Fonda, M.D., Interim Chief Medical Officer, provided a snapshot of the current CalOptima member population. Dr. Fonda noted that CalOptima currently serves approximately 806,000 members. Of those, 12,100 are believed to be experiencing homelessness, and 4148 are in long-term care facilities. Close to 201,000 of the 806,000 total members have one or more medical conditions that place them at higher risk of contracting COVID-19. These medical conditions include: high blood pressure, diabetes, asthma, obesity, serious hear or kidney dysfunction, cancer, lowered immune system, emphysema, and sickle cell. Dr. Fonda noted that roughly one-quarter of these high risk members have either social or medical conditions that contribute to poor health outcomes. Dr. Fonda also commented that many of the recommended actions brought to the Board today have been expedited and are very time sensitive and tailored to address CalOptima's highest risk populations. Dr. Fonda noted that getting members vaccinated as soon as possible will be critical to addressing the COVID-19 public health emergency that is severely impairing public health. Slowing the rapid increase in new infections and easing the overwhelming burden currently being shouldered by the health care delivery system, are extremely important and also very time sensitive.

Board Members had questions on the percentage of CalOptima members that are receptive to receiving the vaccine. Dr. Fonda responded that a vaccination rate of at least 70 percent is required to achieve "herd immunity." Dr. Chau added that OCHCA has completed a survey which indicated that there are significant percentages of the population, especially in certain ethnic groups that are fearful, have received misinformation, or otherwise do not want to be vaccinated. He also added that the County is engaging a communications agency to help to educate the community on the importance of being vaccinated.

Chairman Do stated that it will be critical for CalOptima to see CalOptima-specific responses from the populations we serve and recommended that the Board take urgent action to authorize the CEO to conduct a survey of members and work with OCHCA in a joint outreach effort to target specific CalOptima member populations to achieve higher vaccination rates. Due to the time sensitivity of this

serious risk to public health caused by the COVID-19 health emergency, Chairman Do made a motion to amend the agenda to add an item.

S1. Authorize Amendment to the Agenda to Add an Item based on the COVID-19 health emergency and the urgent risk to public health of CalOptima members not being willing to receive vaccinations.

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors amended the agenda to add an item based on the COVID-19 health emergency and the urgent risk it presents to public health of members not being willing to receive vaccinations. (Motion carried 6-0-0; Director Schoeffel absent)***

S2. Based on the COVID-19 Health Emergency and the Urgent Risk it Presents to Public Health Consider Authorizing the Chief Executive Officer to Conduct a CalOptima Member Survey on the COVID-19 Vaccines and Authorize the CEO, to Collaborate with the Orange County Health Care Agency to Launch a Joint Outreach and Education Campaign to Target Populations about the Importance of Receiving the COVID-19 Vaccines

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors 1.) Authorized the Chief Executive Officer to conduct a CalOptima member survey on the COVID-19 vaccines and 2.) Authorized the CEO to collaborate with the Orange County Health Care Agency to launch a joint Outreach and Education Campaign to target populations about the importance of receiving the COVID-19 vaccines (Motion carried 6-0-0; Director Schoeffel absent)***

REPORTS

3. Consider Expansion and Extension of the Orange County COVID-19 Nursing Home Prevention Program, and its Associated Grant, related to Support of Orange County Nursing Facilities During the Coronavirus Pandemic

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

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors 1.) Approved allocation of Intergovernmental Transfer (IGT) 10 funds in the amount of $1.2 million to support the expansion and extension of the Orange County COVID-19 Nursing Home Prevention Program that will be delivered by the University of California at Irvine (UCI) epidemiological team in Calendar Year (CY) 2021; 2.) Authorized the Chief Executive Officer CEO), with the assistance of Legal Counsel, to amend the Grant Agreement with the Regents of the UCI to expand the scope of services and increase the grant amount, as necessary, to provide for UCI's participation in the extended and expanded Orange County COVID Nursing Home Prevention Program; and 3.) Authorize the CEO to implement the Orange County Nursing Facilities Support Program for CY 2021 prior to CalOptima's receipt of IGT 10 funds from the State of California (Motion carried 6-0-0; Director Schoeffel absent)***

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4. Consider Authorizing Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy in Response to the Coronavirus Pandemic

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Director Chau did not participate in this item due to his role as Director of the Orange County Health Care Agency. Vice Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and left the room during the discussion and vote.

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors 1.) Authorized development and implementation of a Homeless Health Initiative (HHI) – Vaccination Intervention and Member Incentive Strategy, as described, to increase member participation and ensure community safety amid the COVID-19 pandemic, subject to approval of the California Department of Health Care Services (DHCS); 2.) Approved an allocation of HHI funds not to exceed $400,000 to provide two $25 nonmonetary gift cards for members experiencing homelessness who are ages 14 and older for receiving the required two doses of the COVID-19 vaccine; and 3.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contracts/contract amendments with the Orange County Health Care Agency (OCHCA) and/or other entity/entities as appropriate for administration and implementation of this initiative program. (Motion carried 5-0-0; Vice Chair Becerra recused; Director Schoeffel absent)***

5. Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021

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

After discussion, the Board approved an amended motion to include incentives for all CalOptima Medi-Cal members, subject to DHCS approval, for receiving the two doses of the COVID-19 vaccine, including children under 14 years of age.

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors 1.) Authorized the development and implementation of a COVID-19 Vaccination Incentive Program (VIP) for Calendar Year (CY) 2021, as described below, to increase member participation and ensure community safety amid the COVID-19 pandemic, subject to DHCS approval prior to implementation; 2.) Approved the amended recommended allocation of Intergovernmental Transfer (IGT) 10 funds, not to exceed ~~$20~~ $35 million, to provide two $25 nonmonetary gift cards to individual Medi-Cal members ~~age 14 and older~~ for receiving the two required doses of the COVID-19 vaccine (one gift card per shot); 3.) Authorized implementation of the VIP prior to CalOptima's receipt of IGT 10 funds from the State of California; and 4.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel,***

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to enter into a Memorandum of Understanding (MOU), and/or contract or contract amendment with the Orange County Health Care Agency (OCHCA) as appropriate for administration and implementation of the VIP. (Motion carried 5-0-0; Director Tran and Director Schoeffel absent)

6. Consider Ratifying a Letter of Agreement for Emergency Transition of Tustin Care Center Residents and Authorization of an Amendment to the Professional Services Contract with GN Medical Associates dba CareConnect Medical Group for Future Emergency Transition Care Coordination Services

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

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors 1.) Ratified Letter of Agreement (LOA) with GN Medical Associates dba CareConnect Medical Group (CareConnect) to provide emergency transition care coordination services for certain categories of CalOptima Members residing at Tustin Care Center; and 2.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the Professional Services Contract with CareConnect to furnish future emergency transition care coordination services for certain categories of CalOptima Members residing at skilled nursing facilities providing long term care, where the Members' current placement is medically contraindicated and/or due to the immediate, unexpected closure of the current facility due to any cause. (Motion carried 6-0-0; Director Schoeffel absent)***

7. Authorize Health Network Medi-Cal Capitation Rate Increases for the Period of January 1, 2021, through June 30, 2021, due to COVID-Related Expenses

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act and passed the gavel to Vice Chair Becerra. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors 1.) Authorized Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO), except Kaiser Foundation Health Plan, Inc. (Kaiser), on Child, Adult and Seniors and Persons with Disabilities (SPD) Categories of Aid (COA), by 5.0% from current levels for the period of January 1, 2021 through June 30, 2021; 2.) Authorized unbudgeted expenditures up to $9 million to provide funding for Health Network capitation rate adjustments; and 3.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the Medi-Cal PHC, SRG, and HMO Health Network contracts, except Kaiser, to implement the Health Network capitation rate adjustments (Motion carried 5-0-1; Chairman Do abstained; Director Schoeffel absent)***

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BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Board Members thanked the County, Orange County hospitals, providers, and CalOptima staff for the work that has been done to address the COVID-19 pandemic.

ADJOURNMENT

Hearing no further business, Chairman Do adjourned the meeting at 3:50 p.m.

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Sharon Dwiers
Clerk of the Board

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
4. Consider Approval of Modifications to Policy GG.1643: Minimum Physician Standards

Contacts
Emily Fonda, M.D., Interim Chief Medical Officer, (714) 246-8887
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8574

Recommended Action
Approval of modifications to Policy GG.1643: Minimum Physician Standards pursuant to CalOptima's regular review process.

Background/Discussion
Proposed Modifications to Existing Quality Improvement Policy and Procedures
CalOptima staff regularly reviews agency policies to ensure they are up to date and aligned with federal and state health care program requirements, regulatory and contractual obligations, as well as CalOptima operations.

Below is the existing Quality Improvement policy that require modifications:

- ***GG.1643: Minimum Physician Standards [Medi-Cal, OneCare, OneCare Connect and PACE]*** describes the minimum physician standards that must be met for a physician to be credentialed for participation in CalOptima programs. CalOptima staff revised this policy pursuant to the CalOptima annual review process; recommended revisions include the addition of a definition for Precluded or Preclusion and the removal of Section III.A.6, which conflicted with another section of the policy. In addition, an exception for Kaiser Foundation Health Plan, Inc. was added to the policy to accommodate its unique system, which consists of a staff model whereby most providers are employed by Kaiser and go through a specific credentialing process.

Fiscal Impact
The recommended action to approve revisions to CalOptima Policies GG.1643 is operational in nature and is not expected to have a fiscal impact.

Rationale for Recommendation
The recommended action will ensure CalOptima is compliant with contractual and regulatory guidance provided by its regulators (e.g., Department of Health Care Services and Centers for Medicare & Medicaid Services). The updated policy will supersede the prior version.

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

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Attachment

1. GG.1643: Minimum Physician Standards Final Policy Packet

/s/ Richard Sanchez *01/27/2020*
Authorized Signature **Date**

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Policy:	GG.1643Δ
Title:	**Minimum Physician Standards**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	07/01/2016
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administration

I. PURPOSE

This policy identifies the minimum Physician standards that must be met for a Physician to be credentialed for participation in CalOptima programs.

II. POLICY

A. ~~Effective July 1, 2016,~~ CalOptima requires that all new Physicians ~~(as defined in Section IX of this Policy)~~ who wish to provide services to CalOptima members, whether through CalOptima Direct or a CalOptima Health Network, with the exception of Kaiser Foundation Health Plan, Inc., meet the minimum Physician standards as defined in this Policy, and be credentialed in accordance with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners. ~~Kaiser is excluded from this policy.~~ The minimum Physician standards include:

1. Current valid California license to practice.

2. Current valid Drug Enforcement Agency (DEA) certificate.

3. Current professional liability (malpractice) insurance or self-insurance (e.g., trust, escrow accounts, etc.) coverage in the minimum amounts of $1 million per occurrence and $3 million aggregate per year.

4. Not currently excluded, precluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs.

5. Not currently on probation or have an Accusation pending, with their licensing board.

6. Never been excluded from participation in Federal or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in Title 42, United States Code, §1320a-7(a) as follows:

   a. A conviction of a criminal offense related to the delivery of an item or service under Federal or State health care programs;

   b. A felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service;

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c. A felony conviction related to health care fraud; or

d. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

7. No felony conviction in the ten (10) year period prior to the date of execution of the attestation containing these minimum Physician standards.

8. Board certified in their specialty in accordance with CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians, unless exempt from the certification requirements as set forth under that policy.

B. Health Networks that are delegated to perform credentialing and recredentialing shall incorporate the minimum Physician standards into their credentialing processes.

C. A Health Network shall establish policies and procedures to evaluate and select Physician*s* to participate in CalOptima that, at minimum, meet the requirements as outlined in this Policy.

D. The minimum Physician standards will apply to all new, first-time Physician applicants to CalOptima who wish to provide covered services to CalOptima members, without exception.

E. All new Physician*s* must meet the minimum Physician standards to contract with CalOptima or its Health Network*s* to furnish services to CalOptima members and bill and receive reimbursement for such services (subject to compliance with all other applicable CalOptima policies).

III. PROCEDURE

A. For Physicians who wish to provide services to CalOptima members through CalOptima Direct, CalOptima's Provider Relations staff will distribute the minimum Physician standards attestation to Physician*s* as part of a pre-application process. Physicians must satisfy all of the minimum Physician standards to be eligible to be credentialed in CalOptima. Any incomplete attestations shall be returned to the Physician by Provider Relations staff.

1. If the Physician does not fully complete the attestation within one hundred eighty (180) days after receipt of the attestation, the Physician's attestation shall be considered expired.

2. CalOptima's Quality Improvement Department shall review the attestation and documentation and communicate results to the Provider Relations Department. A Physician shall ensure that all information included in the attestation is no more than six (6) months old.

3. A Physician whose completed attestation reflects that he or she meets all of the minimum Physician standards is eligible to receive a credentialing application, and if the credentialing application is approved, a contract to participate in the CalOptima program.

4. A Physician whose attestation reflects that he or she does not meet one (1) or more of the minimum Physician standards shall not be eligible to participate in the CalOptima program.

5. CalOptima's Quality Improvement ~~(QI)~~ Department shall verify all answers and notify the Physician by certified mail that the Physician did not meet the minimum Physician standards within ~~three~~ five (5~~3~~) business days of receipt of a signed and completed attestation.

~~6. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days after receipt of the attestation for any Physician, the Physician's attestation shall be considered expired.~~

B. Health Networks that are delegated to perform credentialing and recredentialing shall adopt a procedure to ensure that new Physicians seeking to contract with that Health Network to provide services to CalOptima members satisfy all minimum Physician standards.

C. CalOptima or a Health Network shall verify the information provided through primary or secondary source verification using industry-recognized verification sources or a credentials verification organization, in accordance with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners.

IV. ATTACHMENT(S)

A. CalOptima Minimum Physician Standards Attestation

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~D.~~E. CalOptima PACE Program Agreement
F. Contract for Health Care Services
~~E.~~G. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
~~F.~~H. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
~~G.A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
~~H.A. Contract for Health Care Services~~
I. Title 42, United States Code (USC), §1320a-7(a)
J. Welfare and Institutions Code (WIC), §14043.36

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
09/07/2016	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
03/23/2016	Regular Meeting of the CalOptima Board of Directors
04/07/2016	Regular Meeting of the CalOptima Board of Directors
05/18/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2016	GG.1643Δ	Minimum Physician Standards	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2017	GG.1643Δ	Minimum Physician Standards	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1643Δ	Minimum Physician Standards	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Accusation	A legal document that begins the formal disciplinary process after an investigation finds evidence that the Physician has violated the laws governing the Physician's practice area, and the violation warrants disciplinary action. An accusation lists the charges and/or the section(s) of law alleged to have been violated, and is served on the Physician.
Health Network	A Physician Hospital Consortium (PHC), ~~Physician Medical Group (PMC),~~ 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.
Physician	For the purposes of this policy, a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Podiatric Medicine (DPM).
Precluded or Preclusion	A type of exclusion, specific to Medicare program. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Policy:	GG.1643Δ
Title:	**Minimum Physician Standards**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	07/01/2016
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administration

I. PURPOSE

This policy identifies the minimum Physician standards that must be met for a Physician to be credentialed for participation in CalOptima programs.

II. POLICY

A. CalOptima requires that all new Physicians who wish to provide services to CalOptima members, whether through CalOptima Direct or a CalOptima Health Network, with the exception of Kaiser Foundation Health Plan, Inc., meet the minimum Physician standards as defined in this Policy, and be credentialed in accordance with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners. The minimum Physician standards include:

1. Current valid California license to practice.

2. Current valid Drug Enforcement Agency (DEA) certificate.

3. Current professional liability (malpractice) insurance or self-insurance (e.g., trust, escrow accounts, etc.) coverage in the minimum amounts of $1 million per occurrence and $3 million aggregate per year.

4. Not currently excluded, precluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs.

5. Not currently on probation or have an Accusation pending, with their licensing board.

6. Never been excluded from participation in Federal or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in Title 42, United States Code, §1320a-7(a) as follows:

   a. A conviction of a criminal offense related to the delivery of an item or service under Federal or State health care programs;

   b. A felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service;

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c. A felony conviction related to health care fraud; or

d. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

7. No felony conviction in the ten (10) year period prior to the date of execution of the attestation containing these minimum Physician standards.

8. Board certified in their specialty in accordance with CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians, unless exempt from the certification requirements as set forth under that policy.

B. Health Networks that are delegated to perform credentialing and recredentialing shall incorporate the minimum Physician standards into their credentialing processes.

C. A Health Network shall establish policies and procedures to evaluate and select Physicians to participate in CalOptima that, at minimum, meet the requirements as outlined in this Policy.

D. The minimum Physician standards will apply to all new, first-time Physician applicants to CalOptima who wish to provide covered services to CalOptima members, without exception.

E. All new Physicians must meet the minimum Physician standards to contract with CalOptima or its Health Networks to furnish services to CalOptima members and bill and receive reimbursement for such services (subject to compliance with all other applicable CalOptima policies).

III. PROCEDURE

A. For Physicians who wish to provide services to CalOptima members through CalOptima Direct, CalOptima's Provider Relations staff will distribute the minimum Physician standards attestation to Physicians as part of a pre-application process. Physicians must satisfy all of the minimum Physician standards to be eligible to be credentialed in CalOptima. Any incomplete attestations shall be returned to the Physician by Provider Relations staff.

1. If the Physician does not fully complete the attestation within one hundred eighty (180) days after receipt of the attestation, the Physician's attestation shall be considered expired.

2. CalOptima's Quality Improvement Department shall review the attestation and documentation and communicate results to the Provider Relations Department. A Physician shall ensure that all information included in the attestation is no more than six (6) months old.

3. A Physician whose completed attestation reflects that he or she meets all of the minimum Physician standards is eligible to receive a credentialing application, and if the credentialing application is approved, a contract to participate in the CalOptima program.

4. A Physician whose attestation reflects that he or she does not meet one (1) or more of the minimum Physician standards shall not be eligible to participate in the CalOptima program.

5. CalOptima's Quality Improvement Department shall verify all answers and notify the Physician by certified mail that the Physician did not meet the minimum Physician standards within five (5) business days of receipt of a signed and completed attestation.

B. Health Networks that are delegated to perform credentialing and recredentialing shall adopt a procedure to ensure that new Physicians seeking to contract with that Health Network to provide services to CalOptima members satisfy all minimum Physician standards.

C. CalOptima or a Health Network shall verify the information provided through primary or secondary source verification using industry-recognized verification sources or a credentials verification organization, in accordance with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners.

IV. ATTACHMENT(S)

A. CalOptima Minimum Physician Standards Attestation

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima PACE Program Agreement
F. Contract for Health Care Services
G. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
H. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
I. Title 42, United States Code (USC), §1320a-7(a)
J. Welfare and Institutions Code (WIC), §14043.36

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
09/07/2016	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
03/23/2016	Regular Meeting of the CalOptima Board of Directors
04/07/2016	Regular Meeting of the CalOptima Board of Directors
05/18/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2016	GG.1643Δ	Minimum Physician Standards	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2017	GG.1643Δ	Minimum Physician Standards	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1643Δ	Minimum Physician Standards	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Accusation	A legal document that begins the formal disciplinary process after an investigation finds evidence that the Physician has violated the laws governing the Physician's practice area, and the violation warrants disciplinary action. An accusation lists the charges and/or the section(s) of law alleged to have been violated, and is served on the Physician.
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.
Physician	For the purposes of this policy, a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Podiatric Medicine (DPM).
Precluded or Preclusion	A type of exclusion, specific to Medicare program. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

CalOptima Minimum Physician Standards Attestation

CalOptima's Board of Directors approved "minimum physician standards" for medical doctors, doctors of osteopathic medicine, and doctors of podiatric medicine, who wish to contract with CalOptima to provide services to CalOptima Members. All physicians in these categories who wish to participate in the CalOptima program must meet all minimum physician standards in order to submit an application for credentialing, the successful approval of which is a pre-requisite to contracting with CalOptima or its contracted Health Networks. All potential providers who have not contracted with CalOptima prior to July 1, 2016 must submit this Attestation in order to be considered for issuance of a credentialing application.

Please answer the following questions either Yes (Y) or No (N).

A. Do you have a current valid California license to practice the profession for which you are seeking participation in CalOptima?	**Y**☐ **N**☐
B. Do you possess a current valid DEA certificate?	**Y**☐ **N**☐
C. (1) were you certified in your specialty within five years of the completion of your residency training, and do you continue to be so certified, by a CalOptima-approved specialty Board, or (2) has it been less than five years since completion of your residency training, and you have been making adequate progress towards being so certified before the expiration of five years from the completion of my residency training.	**Y**☐ **N**☐
D. Do you have current professional liability (malpractice) insurance or self-insurance (e.g. trust, escrow accounts, etc.) coverage in the minimum amounts of $1 million per occurrence and $3 million aggregate per year that covers all aspects of your practice?	**Y**☐ **N**☐
E. Are you currently excluded, precluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs?	**Y**☐ **N**☐
F. Are you currently on probation with the board that issued your license to practice?	**Y**☐ **N**☐
G. Do you currently have an accusation or other disciplinary proceeding pending against you with the board that issued your license to practice?	**Y**☐ **N**☐

(over)

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H. Have you ever been excluded from participation in Federal and/or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in 42 U.S.C. § 1396a-7(a) as follows: (1) a conviction of a criminal offense related to the delivery of an item or service under Federal and/or State health care programs; (2) a felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service; (3) a felony conviction related to health care fraud and/or (4) a felony conviction related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance?

Y☐ **N**☐

I. Do you have any felony convictions in the ten (10)-year period prior to the date of execution of this questionnaire set forth below?

Y☐ **N**☐

By signing this attestation, I hereby: (1) give CalOptima permission to investigate and verify the accuracy of any and all statements and representations in this Attestation; and (2) authorize any relevant person or entity to provide information requested by CalOptima that may be related to any and all statements and representations made in this Attestation.

I declare, under penalty of perjury, under the laws of the State of California, that all statements contained in this Attestation are true and correct. I understand that any and all statements made in this Attestation are subject to verification and that any false or dishonest statement may be grounds for limiting or terminating my participation in CalOptima programs.

Print Name Here: _____**License #**:_____

Physician Signature: _____**Date:**_____
(Stamped Signature is NOT acceptable)

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CalOptima Minimum Physician Standards Attestation

CalOptima's Board of Directors approved "minimum physician standards" for medical doctors, doctors of osteopathic medicine, and doctors of podiatric medicine, who wish to contract with CalOptima to provide services to CalOptima Members. All physicians in these categories who wish to participate in the CalOptima program must meet all minimum physician standards in order to submit an application for credentialing, the successful approval of which is a pre-requisite to contracting with CalOptima or its contracted Health Networks. All potential providers who have not contracted with CalOptima prior to July 1, 2016 must submit this Attestation in order to be considered for issuance of a credentialing application.

Please answer the following questions either Yes (Y) or No (N).

A. Do you have a current valid California license to practice the profession for which you are seeking participation in CalOptima?	**Y**☐ **N**☐
B. Do you possess a current valid DEA certificate?	**Y**☐ **N**☐
C. (1) were you certified in your specialty within five years of the completion of your residency training, and do you continue to be so certified, by a CalOptima-approved specialty Board, or (2) has it been less than five years since completion of your residency training, and you have been making adequate progress towards being so certified before the expiration of five years from the completion of my residency training.	**Y**☐ **N**☐
D. Do you have current professional liability (malpractice) insurance or self-insurance (e.g. trust, escrow accounts, etc.) coverage in the minimum amounts of $1 million per occurrence and $3 million aggregate per year that covers all aspects of your practice?	**Y**☐ **N**☐
E. Are you currently excluded, precluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs?	**Y**☐ **N**☐
F. Are you currently on probation with the board that issued your license to practice?	**Y**☐ **N**☐
G. Do you currently have an accusation or other disciplinary proceeding pending against you with the board that issued your license to practice?	**Y**☐ **N**☐

(over)

H.	Have you ever been excluded from participation in Federal and/or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in 42 U.S.C. § 1396a-7(a) as follows: (1) a conviction of a criminal offense related to the delivery of an item or service under Federal and/or State health care programs; (2) a felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service; (3) a felony conviction related to health care fraud and/or (4) a felony conviction related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance? **Y**☐ **N**☐
I.	Do you have any felony convictions in the ten (10)-year period prior to the date of execution of this questionnaire set forth below? **Y**☐ **N**☐

By signing this attestation, I hereby: (1) give CalOptima permission to investigate and verify the accuracy of any and all statements and representations in this Attestation; and (2) authorize any relevant person or entity to provide information requested by CalOptima that may be related to any and all statements and representations made in this Attestation.

I declare, under penalty of perjury, under the laws of the State of California, that all statements contained in this Attestation are true and correct. I understand that any and all statements made in this Attestation are subject to verification and that any false or dishonest statement may be grounds for limiting or terminating my participation in CalOptima programs.

Print Name Here: _____**License #**:_____

Physician Signature: _____**Date:**_____
(Stamped Signature is NOT acceptable)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Ratification of Modifications to CalOptima Policy and Procedure GG.1352 Private Duty Nursing Care Management of Medi-Cal Eligible Members under the Age of 21

Contacts

Emily Fonda, M.D., Interim Chief Medical Officer, (714) 246-8887
Tracy Hitzeman, R.N., Executive Director, Clinical Operations, (714) 246-8549

Recommended Action

Ratify modifications to CalOptima Policy and Procedure, GG.1352: Private Duty Nursing Care Management of Medi-Cal Eligible Members under the Age of 21, consistent with California Department of Health Care Services (DHCS) requirements.

Background

CalOptima is required to ensure that members have access to all medically necessary Medi-Cal covered services, except for those services that are carved out of CalOptima's contract with the Department of Health Care Services (DHCS). Case management is provided to coordinate the provision of services, including those services that are carved out from CalOptima.

Under the Early and Periodic Screening, Testing, Diagnosis and Treatment (EPSDT) guidelines, Private Duty Nursing (PDN) may be medically necessary for members under age 21. PDN services, provided in a member's home by a registered nurse (RN) or a licensed vocational nurse (LVN), under the direction of a physician, are available for members who need more continuous care than what a home health visiting nurse typically can provide.

DHCS issued guidance to clarify managed care health plan case management responsibilities for members under age 21 who have been approved for PDN services under the EPSDT benefit, which include:

- Providing the member with information about the number of PDN hours that have been approved as well as the case management services available
- Working with enrolled PDN providers to arrange for approved services
- Assisting potentially eligible PDN providers with Medi-Cal provider enrollment

CalOptima Policy GG.1352 Private Duty Nursing Care Management, developed to communicate the requirements of DHCS' guidance and how it would be operationalized, was approved by the CalOptima Board on August 6, 2020. DHCS approved the policy in October 2020.

Discussion

DHCS subsequently sent an Additional Information Request to CalOptima in November 2020, requesting additional revisions to CalOptima's Policy GG.1352: Private Duty Nursing Care Management, which CalOptima management has now completed. The revisions largely involve clarifying that, regardless of whether the Medi-Cal Managed Care Plan has the primary responsibility

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for providing case management for approved private duty nursing services, the EPSDT eligible Medi-Cal member (and/or their personal representative) may contact any Medi-Cal program entity that the member is enrolled in (which may be the managed care plan (i.e., CalOptima), or the Home and Community Based Alternatives Waiver Agency) to request case management for PDN services, but do not create new obligations for CalOptima. CalOptima's obligations (or a health network's obligation for members CalOptima has assigned to a health network) to CalOptima-enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive PDN services and who request case management for their approved PDN services include, but are not limited to: providing information about the number of approved hours; contacting Home Health Agencies (HHAs) and Individual Nurse Providers (INPs) to seek approved PDN services on the Member's behalf; identifying and assisting potentially eligible HHAs and INPs with navigating the process of enrolling to be a Medi-Cal provider; and working with HHAs and enrolled INPs to jointly provide PDN services to Members as needed.

Fiscal Impact

The recommended action to ratify modifications to CalOptima Policy GG.1352 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima staff recommends that the Board approve and adopt the presented CalOptima policies and procedures.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Policy GG.1352 *Private Duty Nursing Care Management*
2. DHCS All Plan Letter 20-012 Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

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Policy:	GG.1352
Title:	**Private Duty Nursing Care Management**
Department:	Medical Management
Section:	Case Management
CEO Approval:	
Effective Date:	08/06/2020
Revised Date:	12/01/2020
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the scope of the provision of case management services for Private Duty Nursing (PDN) services for CalOptima Medi-Cal Members under the age of twenty-one (21) years.

II. POLICY

A. CalOptima and its Health Networks shall provide appropriate preventive, mental health, developmental, and specialty Early and Periodic Screening, Diagnosis, and Treatment medical services, including ~~PDN~~Private Duty Nursing services, under the scope of the CalOptima program to eligible Members under the age of twenty-one (21) years in accordance with applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance, and CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

B. CalOptima or a Health Network ~~shall~~ is required to provide ~~case management~~Case Management services ~~for~~ as set forth in its Medi-Cal contract to all plan enrolled Medi-Cal beneficiaries who are EPSDT eligible ~~Members with approved PDN~~and for whom Medi-Cal Private Duty Nursing services ~~under~~have been approved, including, upon a plan Member's request, Case Management services to arrange for all approved Private Duty Nursing services desired by the ~~EPSDT benefit or~~plan Member, even when CalOptima or a Health Network is not financially responsible for paying for the approved Private Duty Nursing services. Medi-Cal Private Duty Nursing services include Private Duty Nursing services approved under the California Children's Services Program (CCS~~)/Whole-Child Model.~~).

C. ~~Upon a Member's request,~~When CalOptima or a Health Network ~~shall provide case management services to arrange for all authorized PDN service hours for its~~has approved a plan enrolled EPSDT eligible ~~Members even if not financially~~Medi-Cal beneficiary to receive Private Duty Nursing services, under either CCS or Medi-Cal, CalOptima or the Health Network has primary responsibility to provide Case Management for approved Private Duty Nursing services.

~~C.~~D. Regardless of which Medi-Cal program entity has primary responsibility for providing Case Management for the approved Private Duty Nursing services, an EPSDT eligible Medi-Cal beneficiary approved to receive Medi-Cal Private Duty Nursing services, and/or their personal

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representative, may contact any Medi-Cal program entity that the beneficiary is enrolled in (which may be the managed care plan, or the Home and Community Based Alternatives Waiver Agency) to request Case Management for Private Duty Nursing services. The contacted Medi-Cal program entity must then provide Case Management services as described herein to the beneficiary and work collaboratively with the Medi-Cal program entity primarily responsible for ~~the PDN services~~Case Management.

~~D.~~E. CalOptima or a Health Network shall use one ~~(1)~~ or more ~~Medi-Cal enrolled~~ Home Health Agencies (HHA~~) or~~), Individual Nurse Providers (INP~~) to meet a Member's approved PDN service needs~~), or any combination thereof, in providing Case Management services as set forth in the Medi-Cal contract to plan enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive Private Duty Nursing services, including, upon that Member's request, Case Management services to arrange for all approved Private Duty Nursing services desired by the Member, even when CalOptima or the Health Network is not financially responsible for paying for the approved Private Duty Nursing services.

~~E. CalOptima shall issue a notice to every Member under the age of twenty-one (21) years for whom it has currently authorized PDN services on or before July 31, 2020. The notice will explain:~~

~~1. CalOptima's primary responsibility for case management of PDN services;~~

~~2. Describe case management services;~~

~~3. How to access case management services;~~

~~4. How to utilize CalOptima's grievance and appeal process to address difficulties in receiving PDN services or dissatisfaction with case management services;~~

~~5. How to file a Medi-Cal fair hearing, or email DHCS directly at EPSDT@dhcs.ca.gov; and~~

~~6. The number for Disability Rights California at (888) 852-9241 for questions about Member legal rights regarding PDN services.~~

F. CalOptima or a Health Network's obligations to plan enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive Private Duty Nursing services who request Case Management services for their approved Private Duty Nursing services include, but are not limited to:

1. Providing the Member information about the number of Private Duty Nursing hours that they are approved to receive;

2. Contacting enrolled HHAs and enrolled INPs to seek approved Private Duty Nursing services on the Member's behalf;

3. Identifying and assisting potentially eligible HHAs and INPs with navigating the process of enrolling to be a Medi-Cal provider; and

4. Working with HHAs and enrolled INPs to jointly provide Private Duty Nursing services to the Member as needed.

III. PROCEDURE

A. CalOptima or a Health Network shall authorize Medically Necessary ~~PDN~~Private Duty Nursing services in accordance with CalOptima Policy GG.1121: Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services and GG.1508: Authorization and Processing of Referrals.

B. Upon authorization of ~~PDN~~Private Duty Nursing services, CalOptima or a Health Network shall:

1. Notify the Member of the number of ~~PDN~~Private Duty Nursing hours the Member is approved to receive;

2. Arrange for approved ~~PDN~~Private Duty Nursing services on behalf of the Member with enrolled HHAs or INPs;

3. For Members enrolled in CalOptima Direct or CalOptima Community Network, generate a referral for care management in accordance with CalOptima Polices GG.1121: Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services and ~~CalOptima Policy~~ GG.1301: Complex Case Management Process.

4. A case manager shall assist the Member with coordination of ~~PDN~~Private Duty Nursing services, including working with HHAs or INPs to jointly provide ~~PDN~~Private Duty Nursing services to the Member, if necessary, and collaborating with other entities as appropriate.

5. A case manager shall identify potentially eligible HHAs and INPs and assist them with navigating the process of enrolling to become Medi-Cal providers.

C. A Member may choose not to use all approved ~~PDN~~Private Duty Nursing service hours. CalOptima and its Health ~~Network~~Networks must respect this choice.

D. CalOptima or a Health Network shall document and report instances when a Member chooses not to use approved ~~PDN~~Private Duty Nursing services as required by DHCS. A Health Network shall report such instances to the CalOptima Case Management Department in a manner and frequency requested by CalOptima.

E. CalOptima or a Health Network shall document all efforts to locate and collaborate with providers of ~~PDN~~Private Duty Nursing services and with other entities, such as CCS.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012: Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age Of 21
D. CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
E. CalOptima Policy GG.1301: Complex Case Management Process
F. CalOptima Policy GG.1508: Authorization and Processing of Referrals
G. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
H. 42 Code of Federal Regulations §§440.80, 441.18 and 440.169
I. 22 California Code of Regulations §§51184(d), (g)(5) and (h)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
10/13/2020	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
08/06/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/06/2020	GG.1352	Private Duty Nursing Care Management	Medi-Cal
Revised	12/01/2020	GG.1352	Private Duty Nursing Care Management	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
Case Management	Those services furnished to assist individuals eligible under the Medi-Cal State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 Code of Federal Regulations (CFR) sections 441.18 and 440.169. The assistance that case managers provide in assisting eligible individuals is set forth in 42 CFR section 440.169(d) and (e), and 22 California Code of Regulations (CCR) section 51184(d), (g) (5) and (h).
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	~~A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services.~~ Early and Periodic Screening, Diagnostic and Treatment services, a benefit of the State's Medi-Cal program that provides comprehensive, preventative, diagnostic, and treatment services to eligible children under the age of 21, as specified in section 1905(r) of the Social Security Act (42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).). In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any Medically Necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
Home Health Agency (HHA)	For purposes of this Policy, as defined in Health and Safety Code section 1727(a) and used herein, means a public or private organization licensed by the State which provides skilled nursing services as defined in Health and Safety Code section 1727(b), to persons in their place of residence.
Individual Nurse Providers (INP)	A Medi-Cal enrolled registered nurse (RN) or licensed vocational nurse (LVN) who independently provides Private Duty Nursing services in the home to Medi-Cal beneficiaries.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal program, or the United States Social Security Administration, who is enrolled in the CalOptima program.

Term	Definition
Private Duty Nursing	Nursing services provided in a Member's home by a registered nurse (RN) or licensed vocational nurse (LVN~~)~~), under the direction of a Member's physician, for a Member who requires more individual and continuous care than what would be available from a visiting nurse.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

Policy:	GG.1352
Title:	**Private Duty Nursing Care Management**
Department:	Medical Management
Section:	Case Management
CEO Approval:	
Effective Date:	08/06/2020
Revised Date:	12/01/2020
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the scope of the provision of case management services for Private Duty Nursing (PDN) services for CalOptima Medi-Cal Members under the age of twenty-one (21) years.

II. POLICY

A. CalOptima and its Health Networks shall provide appropriate preventive, mental health, developmental, and specialty Early and Periodic Screening, Diagnosis, and Treatment medical services, including Private Duty Nursing services, under the scope of the CalOptima program to eligible Members under the age of twenty-one (21) years in accordance with applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance, and CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

B. CalOptima or a Health Network is required to provide Case Management services as set forth in its Medi-Cal contract to all plan enrolled Medi-Cal beneficiaries who are EPSDT eligible and for whom Medi-Cal Private Duty Nursing services have been approved, including, upon a plan Member's request, Case Management services to arrange for all approved Private Duty Nursing services desired by the plan Member, even when CalOptima or a Health Network is not financially responsible for paying for the approved Private Duty Nursing services. Medi-Cal Private Duty Nursing services include Private Duty Nursing services approved under the California Children's Services Program (CCS).

C. When CalOptima or a Health Network has approved a plan enrolled EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services, under either CCS or Medi-Cal, CalOptima or the Health Network has primary responsibility to provide Case Management for approved Private Duty Nursing services.

D. Regardless of which Medi-Cal program entity has primary responsibility for providing Case Management for the approved Private Duty Nursing services, an EPSDT eligible Medi-Cal beneficiary approved to receive Medi-Cal Private Duty Nursing services, and/or their personal representative, may contact any Medi-Cal program entity that the beneficiary is enrolled in (which may be the managed care plan, or the Home and Community Based Alternatives Waiver Agency) to

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request Case Management for Private Duty Nursing services. The contacted Medi-Cal program entity must then provide Case Management services as described herein to the beneficiary and work collaboratively with the Medi-Cal program entity primarily responsible for Case Management.

E. CalOptima or a Health Network shall use one or more Home Health Agencies (HHA), Individual Nurse Providers (INP), or any combination thereof, in providing Case Management services as set forth in the Medi-Cal contract to plan enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive Private Duty Nursing services, including, upon that Member's request, Case Management services to arrange for all approved Private Duty Nursing services desired by the Member, even when CalOptima or the Health Network is not financially responsible for paying for the approved Private Duty Nursing services.

F. CalOptima or a Health Network's obligations to plan enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive Private Duty Nursing services who request Case Management services for their approved Private Duty Nursing services include, but are not limited to:

1. Providing the Member information about the number of Private Duty Nursing hours that they are approved to receive;

2. Contacting enrolled HHAs and enrolled INPs to seek approved Private Duty Nursing services on the Member's behalf;

3. Identifying and assisting potentially eligible HHAs and INPs with navigating the process of enrolling to be a Medi-Cal provider; and

4. Working with HHAs and enrolled INPs to jointly provide Private Duty Nursing services to the Member as needed.

III. PROCEDURE

A. CalOptima or a Health Network shall authorize Medically Necessary Private Duty Nursing services in accordance with CalOptima Policy GG.1121: Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services and GG.1508: Authorization and Processing of Referrals.

B. Upon authorization of Private Duty Nursing services, CalOptima or a Health Network shall:

1. Notify the Member of the number of Private Duty Nursing hours the Member is approved to receive;

2. Arrange for approved Private Duty Nursing services on behalf of the Member with enrolled HHAs or INPs;

3. For Members enrolled in CalOptima Direct or CalOptima Community Network, generate a referral for care management in accordance with CalOptima Polices GG.1121: Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services and GG.1301: Complex Case Management Process.

4. A case manager shall assist the Member with coordination of Private Duty Nursing services, including working with HHAs or INPs to jointly provide Private Duty Nursing services to the Member, if necessary, and collaborating with other entities as appropriate.

5. A case manager shall identify potentially eligible HHAs and INPs and assist them with navigating the process of enrolling to become Medi-Cal providers.

C. A Member may choose not to use all approved Private Duty Nursing service hours. CalOptima and its Health Networks must respect this choice.

D. CalOptima or a Health Network shall document and report instances when a Member chooses not to use approved Private Duty Nursing services as required by DHCS. A Health Network shall report such instances to the CalOptima Case Management Department in a manner and frequency requested by CalOptima.

E. CalOptima or a Health Network shall document all efforts to locate and collaborate with providers of Private Duty Nursing services and with other entities, such as CCS.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012: Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age Of 21
D. CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
E. CalOptima Policy GG.1301: Complex Case Management Process
F. CalOptima Policy GG.1508: Authorization and Processing of Referrals
G. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
H. 42 Code of Federal Regulations §§440.80, 441.18 and 440.169
I. 22 California Code of Regulations §§51184(d), (g)(5) and (h)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
10/13/2020	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
08/06/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/06/2020	GG.1352	Private Duty Nursing Care Management	Medi-Cal
Revised	12/01/2020	GG.1352	Private Duty Nursing Care Management	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
Case Management	Those services furnished to assist individuals eligible under the Medi-Cal State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 Code of Federal Regulations (CFR) sections 441.18 and 440.169. The assistance that case managers provide in assisting eligible individuals is set forth in 42 CFR section 440.169(d) and (e), and 22 California Code of Regulations (CCR) section 51184(d), (g) (5) and (h).
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Early and Periodic Screening, Diagnostic and Treatment services, a benefit of the State's Medi-Cal program that provides comprehensive, preventative, diagnostic, and treatment services to eligible children under the age of 21, as specified in section 1905(r) of the Social Security Act (42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).). In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any Medically Necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
Home Health Agency (HHA)	For purposes of this Policy, as defined in Health and Safety Code section 1727(a) and used herein, means a public or private organization licensed by the State which provides skilled nursing services as defined in Health and Safety Code section 1727(b), to persons in their place of residence.
Individual Nurse Providers (INP)	A Medi-Cal enrolled registered nurse (RN) or licensed vocational nurse (LVN) who independently provides Private Duty Nursing services in the home to Medi-Cal beneficiaries.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
Member	A 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.
Private Duty Nursing	Nursing services provided in a Member's home by a registered nurse (RN) or licensed vocational nurse (LVN), under the direction of a Member's physician, for a Member who requires more individual and continuous care than what would be available from a visiting nurse.

Term	Definition
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: May 15, 2020

ALL PLAN LETTER 20-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21

PURPOSE:
The purpose of this All Plan Letter (APL) is to clarify Medi-Cal managed care health plan (MCP) obligations related to the provision of case management services for Private Duty Nursing (PDN) services that have been approved for members under the age of 21 pursuant to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

BACKGROUND:
EPSDT is a Medi-Cal benefit that provides a comprehensive array of preventive, diagnostic, and treatment services, including but not limited to case management, for individuals under the age of 21, as set forth in the Social Security Act (SSA), section 1905(r) and Title 42 of the United States Code (USC), section 1396d(r).[1, 2] In California, the EPSDT benefit is established in Welfare and Institutions Code (WIC).[3, 4]

MCPs are generally required to provide and cover all medically necessary Medi-Cal covered services, other than those services carved out of the MCP contract with the Department of Health Care Services (DHCS). Even for carved-out services, MCPs are responsible for providing case management to ensure the provision of medically necessary services, whether those services are delivered within or outside of the MCP's provider network. State law provides that for individuals under 21 years of age, a service is medically necessary or a medical necessity if it meets the standards set forth in 42

[1] SSA, section 1905 is available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
[2] 42 USC, section 1396d is available at: http://uscode.house.gov/view.xhtml?req=(title:42%20section:1396d%20edition:prelim
[3] See WIC section 14132(v), available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.&lawCode=WIC
[4] For more information regarding EPSDT, see APL 19-010, "Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21," or any superseding APL. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

USC, section 1396d(r)(5).[5] Comprehensive case management for medically necessary services, including both basic and complex case management, is described in MCP contracts.[6] Further, the MCP contracts set forth requirements for Services for Children with Special Health Care Needs, which include case management and coordination of care.[7]

For some MCP members under age 21, PDN services may be medically necessary. PDN services are nursing services provided in a member's home by a registered nurse (RN) or licensed vocational nurse (LVN) for a member who requires more individual and continuous care than what would be available from a visiting nurse.[8] RNs and LVNs providing PDN services to MCP members must either be Medi-Cal enrolled as individual providers who offer PDN services independently, or they may offer services through a Medi-Cal enrolled home health agency (HHA).[9] An HHA is a state-licensed public or private organization that provides in-home skilled nursing services.[10]

In some cases, MCPs authorize PDN services. In other cases, an MCP member may be approved to receive PDN services through a program outside of Medi-Cal managed care, such as California Children's Services (CCS) or Medi-Cal fee-for-service. For plans

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[5] See WIC section 14059.5(b), stating, "(1) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. (2) The department and its contractors shall update any model evidence of coverage documents, beneficiary handbooks, and related material to ensure the medical necessity standard for coverage for individuals under 21 years of age is accurately reflected in all materials." See also 42 USC, section 1396d(r)(5) "Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."
http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14059.5.&lawCode=WIC

[6] MCP Contracts, Exhibit A, Attachment 11. MCP boilerplate contracts are available at:
https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

[7] MCP Contracts, Exhibit A, Attachment 11.

[8] See Title 42 of the Code of Federal Regulations, section 440.80, available at:
https://www.ecfr.gov/cgi-bin/text-idx?SID=2888566bb0df8b362250dc4c2a3311ab&mc=true&node=pt42.4.440&rgn=div5#se42.4.440_180

[9] For more information about provider enrollment, see APL 19-004, "Provider Credentialing / Recredentialing and Screening / Enrollment," or any superseding APL.

[10] See Health and Safety Code section 1727, available at:
http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1727.&lawCode=HSC

participating in the CCS Whole Child Model program, there is no carve-out of PDN services for CCS eligible conditions, and the MCP authorizes PDN services for both CCS covered conditions and under EPSDT.

POLICY:
MCPs are contractually obligated to provide case management services to members. Specifically, for Medi-Cal eligible members under the age of 21 who have had PDN services approved, MCPs are required to provide case management, as set forth in the MCP contract, and to arrange for all approved PDN services, whether or not the MCP is financially responsible for the PDN services.[11]

If the MCP is the entity that approved the PDN services for an eligible member under the age of 21, the MCP is primarily responsible for providing case management to arrange for all approved PDN service hours. If another entity, such as CCS, has authorized PDN services and is primarily responsible for providing case management for those PDN services, MCPs must still provide case management as necessary, including, at the member's request, arranging for all approved PDN services. MCPs must use one or more Medi-Cal enrolled HHAs or individual nurse providers, or any combination thereof, to meet the member's approved PDN service needs.

PDN Case Management Responsibilities
When an eligible member under the age of 21 is approved for PDN services and requests that the MCP provide case management services for those PDN services, the MCP obligations include, but are not limited to:

- Providing the member with information about the number of PDN hours the member is approved to receive;
- Contacting enrolled HHAs and enrolled individual nurse providers to seek approved PDN services on behalf of the member;
- Identifying potentially eligible HHAs and individual nurse providers and assisting them with navigating the process of enrolling to become a Medi-Cal provider; and
- Working with enrolled HHAs and enrolled individual nurse providers to jointly provide PDN services to the member.

Members may choose not to use all approved PDN service hours, and MCPs are permitted to respect the member's choice. MCPs must document instances when a member chooses not to use approved PDN services. When arranging for the member to

[11] Acceptance of available PDN services is at the member's discretion. Members are not required to use all approved PDN service hours.

receive authorized PDN services, MCPs must document all efforts to locate and collaborate with providers of PDN services and with other entities, such as CCS.

Policies and Procedures

MCPs are required to issue new or revised policies and procedures that comply with the requirements of this APL. Within 90 days of the release of this APL, MCPs must submit copies of the new or updated policies and procedures to their Managed Care Operations Division (MCOD) Contract Manager for review and approval.

Notice to Members

The MCP is required to issue a notice to every member under the age of 21 for whom it has currently authorized PDN services on or before July 31, 2020. The notice must:

- Explain that the MCP has primary responsibility for case management of PDN services.
- Describe the case management services available to the member in connection with PDN services, as set forth above.
- Explain how to access those services.
- Include a statement that the member may:
    - Utilize the MCP's existing grievance and appeal procedures to address difficulties in receiving PDN services or their dissatisfaction with their case management services;
    - File a Medi-Cal fair hearing as provided by law; or
    - Email DHCS directly at EPSDT@dhcs.ca.gov.
- Include a statement that if the member has questions about their legal rights regarding PDN services, they may contact Disability Rights California at (888) 852-9241.

Monitoring & Oversight

DHCS will audit MCP compliance with the PDN services case management policy outlined in this APL and the case management requirements set forth in the MCP's contract with DHCS. If the MCP fails to comply with the requirements of this APL or the case management requirements in the MCP's contract, DHCS may require a corrective action plan and/or assess monetary penalties as provided for in the MCP contract and any applicable state or federal statutes and regulations.[12]

[12] For more information on corrective action, see APL 18-003, "Administrative and Financial Sanctions," or any superseding APL.

MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all subcontractors and network providers.

If you have any 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

CalOptima Board Action Agenda Referral

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Consider Authorizing Modification and Extension of License Agreement with the County of Orange for Use of Space at the Orange County Community Service Center Annex

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Action

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to negotiate and execute a modification of and extension to the License Agreement with the County of Orange, as amended by the First Amendment to License, for up to an additional four years through June 30, 2025 or other determined date, which allows use of approximately 362 square feet of space along with common areas at the Orange County Community Service Center Annex (OCCSCA), located at 15496 Magnolia Street, Suite 111, Westminster, CA 92683.

Background

As a public agency and community health plan that serves the Medi-Cal population in Orange County, CalOptima has been committed to member outreach, health education and engagement since its inception. By actively engaging CalOptima members in coordination with community-based organizations, we increase opportunities for our members to receive information regarding our programs, learn about their benefits and be more proactive participants in their own health care.

Beginning in 2008, CalOptima utilized space at the main County Community Service Center (CCSC) office at no cost to CalOptima to offer monthly health education seminars to increase members knowledge about CalOptima and provide information to support our members' health care needs. Due to growth in membership and programs, and increased interest in the health education seminars, the space at the main office was insufficient to meet CalOptima and member needs for services at the main CCSC office. In May 2016, Orange County Social Services Agency informed CalOptima of an opportunity to expand our capacity at the CCSC office by licensing space located across the parking lot from the main CCSC office (referred to as the OCCSCA).

Effective August 5, 2016, CalOptima entered into a License Agreement for one dedicated office and access to a shared conference room for 50 percent of the time at the OCCSCA. The License at OCCSA for CalOptima's use of this space as a satellite office was effective through June 30, 2017. On June 1, 2017, CalOptima's Board of Directors authorized the CEO to extend the License Agreement for an additional four years through June 30, 2021. We are informed that the County's lease rent for July 1, 2020 – June 30, 2021 is $7,129 per month ($3.36 per square foot) for the OCCSCA space. The total leased space for the OCCSCA is comprised of 2,080 square feet, with CalOptima's use of 109 square feet for the dedicated office, 253 square feet for the shared conference room, and estimated 21 percent use of the common area. CalOptima's current License fee for July 1, 2020 through June 30, 2021 is $1,705.72 per month. CalOptima's License fee includes the use of space, as well as utilities, information technology, janitorial and telephone services. These expenses

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are equivalent to approximately 24% of the County's monthly rent under the lease. The OCCSCA is centrally located in the county and may be more convenient for certain CalOptima members who reside in the cities of Santa Ana, Garden Grove and Westminster. Since September 2016, CalOptima staff has been on-site to provide information and education about CalOptima's programs and services, enhanced customer service support, and additional monthly educational seminars.

Initially, staff from various CalOptima departments rotated on-site at OCCSCA to serve members, including staff from the Behavioral Health Integration, Program of All-Inclusive Care (PACE), OneCare Connect Sales and Marketing, Customer Service and Community Relations departments. Services offered on-site include information and referrals for our programs and services, information and enrollment in the PACE and OneCare Connect programs, assistance with navigating health care benefits and customer service-related issues including provider and health network selection, referrals, and replacement ID cards.

In January 2017, CalOptima started offering New Member Orientation for our Vietnamese-speaking members at this location. Starting late May 2017, a full-time, bi-lingual Customer Service Representative was designated to the satellite office at OCCSCA to serve CalOptima members and potential members. Services expanded to include addressing billing inquiries, assisting with Protected Health Information (PHI) forms, reviewing pharmacy/medication denials and cases, filing grievances and appeals, and opening coordination of care cases.

CalOptima has also collaborated with community partners and internal departments to increase awareness and utilization of our satellite office. Since opening, CalOptima has hosted health education seminars on a monthly basis. The Population Health Management Department hosted mobile mammogram events on March 10, 2018 and October 29, 2019 in collaboration with Susan G. Komen Orange County, Orange County Health Care Agency Every Woman Counts Program and Alinea Mobile Imaging. This event targeted CalOptima Direct and CalOptima Community Network members who lived within a 5-mile radius of the satellite office and who were due for their breast cancer screening.

In addition to CalOptima's services, the OCCSCA offers a variety of health and human services to local residents including resources and referrals, application assistance and education workshops to assist with housing, mental and public health and support services for older adults. Representatives from Orange County Health Care Agency mental health specialist and public health nurse, Orange County Housing Authority, the Family Caregiver Resource Center, the Council on Aging and the Office on Aging are available on-site to assist members.

In 2019, the total number of visitors assisted by CalOptima staff ranged from 38 to 73 individuals per month or an average of one to three per day. In March 2020, the satellite office closed due to COVID-19. To ensure the safety and well-being of our members and prevent the spread of COVID-19, health education seminars, new member orientations, workshops and events are currently on hold; however, since July 2020, CalOptima's Customer Service Representative has been able to serve our members visiting the satellite office via telephonic support. In discussions with the County regarding COVID impacts, the County has informally advised that CalOptima's use of the designated office space and

the shared space will not be impacted due to COVID-19. The County is taking steps to ensure the safety of the community and staff by implementing social distancing requirements and limiting the number of community members entering the building.

Discussion

The License Agreement, like the County's current Lease Agreement, is due to expire on June 30, 2021. While the County's current Lease Agreement includes an option to extend the term beyond June 30, 2021 for an additional four (4) year term, the CalOptima License Agreement does not. If the County extends its Lease Agreement, and CalOptima extends the License Agreement the new termination date for both agreements would be June 30, 2025. The County has until the end of February 2021 to inform the landlord of its intent to exercise its option to extend. Once exercised, the landlord and the County may begin negotiations. Due to the potential for a lengthy process for determining the rental rate, CalOptima may not know if the space will remain available, and, if so, what the monthly License fee will be until shortly before the end of the current term.

CalOptima staff is seeking Board authority to negotiate an extension of the existing License Agreement to coincide with the County's lease term, subject to the County's extension of the lease, through June 30, 2025. The Board's approval of this item would authorize CalOptima staff to have direct discussions with the County regarding its plans, if any, to extend the Lease Agreement and CalOptima's License Agreement and to begin discussions about the extensions without waiting for the County and the landlord to come to final agreement on the Lease terms. CalOptima staff is also seeking Board authority to enter into a modification and extension of the License Agreement to extend the term for up to four years under the same provisions, subject to the monthly License fee (including utility and other services currently provided) not exceeding the same proportional rate (24%) of the monthly rent negotiated between the landlord and County. Any modifications to insurance requirements will be reviewed by the Director of Financial Compliance, with the assistance of Legal Counsel, and if needed, CalOptima's broker, to confirm that CalOptima can meet the requirements and to ensure consistency with current market practices. In the event of any other material changes, CalOptima will return to the Board for further authorization. The monthly License fees and insurance expenses for the extended years are expected to be included as part of the annual budgeting process.

The licensed site establishes a valuable CalOptima presence in the community and is available to provide local access and information to members regarding CalOptima benefits and health education to support their health care needs. This office is centrally located in Orange County and provides CalOptima with an opportunity to serve our members in their community, while establishing CalOptima's presence in the community. Staff recommends authorization to negotiate with the County, and for the Chief Executive Officer, with assistance of legal counsel, authorization to execute an extension and modification to the License Agreement as set forth above. The Board's approval will allow time for staff to engage with the County and to complete any documentation necessary prior to the end of the existing term of the License Agreement.

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Fiscal Impact

The current License Agreement with the County of Orange for CCSC is a budgeted item in the amount of $21,000 under the Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020. Funding for the recommended action to modify and extend the License Agreement through June 30, 2025, will be included in the CalOptima Fiscal Year (FY) 2021-22 Operating Budget and future operating budgets.

Rationale for Recommendation

As part of CalOptima's mission, staff works toward providing access to health care services for our members. By operating a satellite site in central Orange County, CalOptima is able to expand services to our members and maintain a local presence in the community.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. CalOptima Board Action dated August 4, 2016 Consider Authorization of License Agreement with the County of Orange for Usage of Space at the County Community Service Center.
3. CalOptima Board Action dated June 1, 2017 Consider Authorizing Extension of License Agreement with the County of Orange for Use of Space at the County Community Services Center.
4. First Amendment to Fully Executed License Agreement between CalOptima and the County of Orange.
5. County of Orange Board of Supervisors Agenda Item 17-00473 dated June 6, 2017 Lease Amendment for Multi-Agency Use at 15460 and 15496 Magnolia, Westminster Attachment F Redlined Lease 15496 Magnolia

/s/ Richard Sanchez — *01/27/2021*

Authorized Signature — **Date**

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Attachment to the February 4, 2021 Board of Directors Meeting – Agenda Item 6

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
The County of Orange Social Services Agency	500 N. State College Blvd.	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

36. Consider Authorization of License Agreement with the County of Orange for Usage of Space at the County Community Service Center

Contact

Phil Tsunoda, Executive Director Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a one year license agreement with the County of Orange for non-exclusive use of approximately 362 square feet of space at the County Community Service Center (CCSC), located at 15496 Magnolia Street, Westminster, CA 92683; and
2. Approve allocation of $22,538 from existing reserves to fund the license agreement through June 30, 2017.

Background

The current County Community Service Center (CCSC) facility provides a variety of health and human services to local residents, including referrals for mental and public health, resources for the homeless, legal assistance, marriage licenses and passport services. The current CCSC also offers residents help to apply for Medi-Cal and Medicare. Representatives from the Health Care Agency, Social Services Agency, Office on Aging, Department of Housing, and County Clerk-Recorder Department are available on designated days.

As a public and community health plan that serves the low-income Medi-Cal population in Orange County, CalOptima has been committed to member outreach, health education and engagement since its inception. By actively engaging our members in efforts with our community-based organization partners and through health education workshops, health fairs and seminars, we increase opportunities for our members to receive information regarding our programs, learn about their benefits and be more proactive participants in their own health care.

Since 2008, CalOptima has utilized available space at the current CCSC offer health education seminars. At the current CCSC location, CalOptima currently hosts one health education seminar per month to assist members about health care programs. Topics at some of the recent health education seminars have included:

- Program for All-Inclusive Care for the Elderly (PACE)
- OneCare Connect
- Medicare 2016: New Policy and Changes
- Memory Loss, Dementia, and Alzheimer's Disease
- Understanding Social Security Programs and Benefits
- Consult with Three Cardiologists: Learn about Stroke and Peripheral Arterial Disease

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While CalOptima members reside throughout Orange County, a large percentage reside in the central portion of the county. Residents in the cities of Santa Ana, Garden Grove, and Westminster comprise over 30% of CalOptima's total membership.

The current CCSC, located in the City of Westminster, has proven to be a centrally-located space for CalOptima members to attend health education seminars, and obtain information about programs and services. In conjunction with services offered by various county departments, the County of Orange provided CalOptima with use of the CCSC at no cost as a service to community residents.

Due to CalOptima's growth in membership and programs, and the resulting increase in interest in CalOptima's health education seminars at CCSC, additional space would better accommodate the needs of CalOptima members. At recent seminars, members have been turned away due to lack of space. While staff has addressed this issue in the short term by hosting multiple seminar sessions on the same day, the current space presents logistical challenges.

Earlier this year, the County of Orange informed CalOptima of its decision to expand capacity at the CCSC by leasing additional space located across the parking lot from the existing facility effective July 1, 2016 for use by the Orange County Social Services Agency. The leased space would provide the County with expanded space for its programs and also provide CalOptima with the opportunity to enter into a license agreement with the County that would provide CalOptima with a dedicated office, as well as shared use of a conference room space in order to offer more health education seminars and other community events each month.

Discussion

Staff recommends authorization of the license agreement with the County of Orange, which would allow CalOptima to have one dedicated office, along with shared use of a conference room. The County's recently added CCSC space has a conference room (which is 253 square feet in size) that is adjacent to the entryway of the suite. Additionally, the County of Orange is proposing to remove the wall between the conference room and the entryway (at CalOptima's expense), which would create a larger space for community events, such as the health education seminars. While the original CCSC has a maximum capacity to hold events with 20 participants, the new CCSC space will have the capacity to hold events with approximately 50 participants.

The County's newly leased CCSC space is comprised of 2,080 square feet total. The County's primary lease agreement with the property owner is for $5,000 per month (approximately $2.40 per square foot) and includes seven offices as well as a conference room. As proposed, CalOptima would have access to the conference room for 50% of the time, one dedicated office, and the common area of the leased space.

Based on estimates provided by the County of Orange, the monthly expenses to CalOptima for its portion of the space is $1,453.02. This cost estimate is based on: 253 square footage of conference room space, 109 square foot dedicated CalOptima office, and prorated 21% of total common area. The County of Orange estimates the improvement costs to remove the wall between the conference room and the entryway at $7,646 in one-time costs to CalOptima.

Staff has conducted a review of the County of Orange's sub-lease agreement. Based on current commercial real estate trends, the proposed license is well within market pricing.

	Total Amount
License Fee (August 2016 - June 2017) • Fee includes leased space, IT services, telephone services, janitorial services, and electrical/utilities	$14,892
Improvement costs (Removal of wall)	$7,646
Total	**$22,538**

The County of Orange's primary lease agreement for the annexed CCSC is for the period of July 1, 2016 through June 30, 2017. Staff is proposing CalOptima's license for the CCSC annex to be for the period of August 5, 2016 through June 30, 2017.

Fiscal Impact
The recommended action to execute a license agreement with the County of Orange through June 30, 2017, for usage of space at the CCSC will be funded through an allocation of $22,538 from existing reserves.

Rationale for Recommendation
As part of CalOptima's mission, staff works towards providing access to health care services for our members. In the past eight years, CalOptima's participation at the CCSC has proved extremely valuable, as we have helped provide access to information about programs and benefits, as well as critical health education to members. Due to CalOptima's new programs and substantial increase in overall membership, the current CCSC location no longer meets the needs of our members. The opportunity to partner with the County of Orange and sub-lease additional space, provides a low-cost solution to not only meet the existing logistical challenges of the health education seminars, but also provides an opportunity for CalOptima to expand its services to members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Draft County of Orange CCSC Annex Proposed License Agreement with CalOptima for new CCSC location
2. CCSC Cost Apply
3. County of Orange Primary Lease Agreement for new CCSC location
4. Quotation for Tenant Improvements

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

LICENSE AGREEMENT

This LICENSE AGREEMENT (**"License"**) is made and entered into _____ , 2016 (**"Effective Date"**), by and between, CALOPTIMA, (hereinafter referred to as **"LICENSEE"**) and COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**) without regard to number and gender. LICENSEE and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**."

RECITALS

I. COUNTY leases that certain real property located at 15496 Magnolia in the City of Westminster, (**"County Property"**) pursuant to a lease dated July 1, 2016 for COUNTY's Social Services Agency's (**"SSA"**) Orange County Community Service Center Annex (**"OCCSCA"**).

II. The Services provided by LICENSEE will include a convenient on-site source while SSA clients are at the SSA Office.

III. COUNTY agrees to provide LICENSEE sufficient office space within the SSA Office for LICENSEE to provide the Services.

NOW THEREFORE, in consideration of the Recitals above, incorporated herein by reference, COUNTY and LICENSEE do hereby agree as follows:

1. DEFINITIONS (AMLC-2.1 S)

The following words in this License have the significance attached to them in this clause, unless otherwise apparent from context:

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"Chief Real Estate Officer" means the Chief Real Estate Officer, County Executive Office, County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"**Facilities Services Manager**" means the Manager of the Social Services Agency, Facilities Services, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Director of Social Services Agency.

"Risk Manager" means the Manager of County Executive Office, Risk Management, for the County of Orange, or upon written notice to LICENSEE, such entity as shall be designated by the County Executive Officer.

"SSA Director" means the Director of Social Services Agency, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. TERM (AMLC-3.1 N)

The term of this License shall commence on the Effective Date and terminate on June 30, 2017, unless terminated as provided in Clause 3 (TERMINATION) of this License.

3. TERMINATION (AMLC-3.3 S)

This License shall be revocable by either COUNTY's SSA Director or LICENSEE at any time; however, as a courtesy the Parties will attempt to give thirty (30) days written notice to the other Party upon revocation.

4. LICENSE AREA (AMLC-4.2 N)

COUNTY grants to LICENSEE the non-exclusive right to use that certain property hereinafter referred to as **"License Area,"** shown on Exhibit A, attached hereto and by reference made a part hereof, for the purposes set forth in Clause 6 (USE) of this License together with non-exclusive, in common use of COUNTY's elevators, stairways, washrooms, hallways, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to LICENSEE's License Area created by this License.

During the term of this License, the dates and times for use of the License Area will be determined by the Facilities Services Manager, and the location of the License Area is subject to relocation at the sole discretion of the Facilities Operations Manager.

5. PARKING (AMLC-4.4 S)

Throughout the term of this License COUNTY shall provide one (1) parking space for LICENSEE's free and non-exclusive use.

6. USE (AMLC-5.1 N)

LICENSEE's use of the License Area shall be limited to general office to provide clients with health related workshops and information regarding their Medi-Cal benefits.

LICENSEE agrees not to use the License Area for any other purpose nor to engage in or permit any other activity within or from the License Area without prior written permission from the Facilities Services Manager. LICENSEE further agrees not to conduct or permit to be conducted any public or private nuisance in, on, or from the License Area, not to commit or permit to be committed waste on the License Area, and to comply with all governmental laws and regulations in connection with its use of the License Area.

NO ALCOHOLIC BEVERAGES OR TOBACCO PRODUCTS SHALL BE SOLD OR CONSUMED WITHIN THE LICENSE AREA.

7. LICENSE FEE (AMLC-6.1 S)

LICENSEE agrees to pay COUNTY from and after the effective date of this License according to the following schedule:

MONTH	MONTHLY LICENSE FEE
1	$0.00
2	$361.73
3	$1,453.02
4	$1,453.02
5	$1,453.02
6	$1,453.02
7	$1,453.02
8	$1,453.02
9	$1,453.02
10	$1,453.02
11	$1,453.02
12	$1,453.02

The monthly License Fee shall be payable in advance, without prior notice or demand on the first day of each calendar month while this License is in effect without deduction or offset in lawful money of the United States.

In the event the obligation to pay the License Fee begins or terminates on some day other than the first day or last day of the month, the License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month. The fee for any partial calendar month during which this License becomes effective will be payable on such effective date.

8. PAYMENT PROCEDURE (AMLC-7.1 N)

All payments shall be delivered to the County of Orange, Office of the Auditor-Controller, P. O. Box 567 (630 N. Broadway), Santa Ana, California 92702. The designated place of payment may be changed at any time by COUNTY upon ten (10) days written notice to LICENSEE. License Fee payments may be made by check payable to the County of Orange. Said License Fee payment shall include a payment voucher indicating that the payment is for the monthly License Fee for office space at the Orange County Community Service Center Annex in Westminster, California. A duplicate copy of the payment voucher shall be mailed to the County of Orange, Social Services Agency, 500 N. State College Boulevard, Orange, California,

92868, Attention: Facilities Services Manager. LICENSEE assumes all risk of loss if payments are made by mail.

No payment by LICENSEE or receipt by COUNTY of a lesser amount than the payment due shall be deemed to be other than on account of the payment due, nor shall any endorsement or statement on any check or any letter accompanying any check or payment as payment be deemed an accord and satisfaction, and COUNTY shall accept such check or payment without prejudice to COUNTY's right to recover the balance of said payment or pursue any other remedy in this License.

9. CHARGE FOR LATE PAYMENT (AMLC-7.2 S)

LICENSEE hereby acknowledges that late payment of sums due hereunder will cause COUNTY to incur costs not contemplated by this License, the exact amount of which will be extremely difficult to ascertain. Such costs include but are not limited to costs such as administrative processing of delinquent notices, increased accounting costs, etc.

Accordingly, if any payment pursuant to this license is not received by COUNTY by the due date, a late charge of one and one-half percent (1.5%) of the payment due and unpaid plus $100 shall be added to the payment, and the total sum shall become immediately due and payable to the COUNTY. An additional charge of one and one-half percent (1.5%) of said payment, excluding late charges, shall be added for each additional month that said payment remains unpaid.

LICENSEE and COUNTY hereby agree that such late charges represent a fair and reasonable estimate of the costs that COUNTY will incur by reason of LICENSEE's late payment.

Acceptance of such late charges (and/or any portion of the overdue payment) by COUNTY shall in no event constitute a waiver of LICENSEE's default with respect to such overdue payment, or prevent COUNTY from exercising any of the other rights and remedies granted hereunder.

10. UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N)

COUNTY shall be responsible for all charges for all utilities (water, gas and sewer),. County shall be responsible for all maintenance and repairs (including but not limited to: fire alarm, fire extinguisher, HVAC system, elevator maintenance, landscaping, pest control, and trash). COUNTY shall be responsible for telephone service, internet service and janitorial service. All charges for services provided by COUNTY pursuant to this Clause shall be included in LICENSEE's "MONTHLY LICENSE FEE" pursuant to Clause 7. (LICENSE FEE) of the License.

11. CONSTRUCTION AND/OR ALTERATION BY LICENSEE (AMD2.1 S)

COUNTY's Consent. No structures, improvements, or facilities shall be constructed, erected, altered, or made by LICENSEE within the License Area without prior written consent of the Facilities Services Manager. Any conditions relating to the manner, method, design, and construction of said structures, improvements, or facilities fixed by the Facilities Services Manager as a condition to granting such consent, shall be conditions hereof as though originally stated herein. LICENSEE may, at any time and at its sole expense, install and place business fixtures and equipment within License Area.

Strict Compliance with Plans and Specifications. All improvements constructed by LICENSEE within the

License Area shall be constructed in strict compliance with detailed plans and specifications approved by the Facilities Services Manager.

COUNTY shall contract with a licensed contractor to remove the existing wall between the "Reception Area" and "Room #1" as depicted in Exhibit B, to replace existing carpet, and repair any areas resulting from removing said wall. LICENSEE shall reimburse COUNTY in the amount not to exceed Seven Thousand six hundred forty-five dollars and fifty-five cents ($7,645.55) within twenty (20) business days of COUNTY's submittal to LICENSEE of an invoice from COUNTY.

12. MECHANICS LIENS OR STOP-NOTICES (AMD4.1 S)

LICENSEE shall at all times indemnify, defend with counsel approved in writing by COUNTY and save COUNTY harmless from all claims, losses, demands, damages, cost, expenses, or liability costs for labor or materials in connection with construction, repair, alteration, or installation of structures, improvements, equipment, or facilities within the License Area, and from the cost of defending against such claims, including attorney fees and costs.

In the event a lien or stop-notice is imposed upon the License Area as a result of such construction, repair, alteration, or installation, LICENSEE shall either:

A. Record a valid Release of Lien, or

B. Procure and record a bond in accordance with Section 3143 of the Civil Code, which frees the License Area from the claim of the lien or stop-notice and from any action brought to foreclose the lien.

Should LICENSEE fail to accomplish either of the two optional actions above within fifteen (15) days after the filing of such a lien or stop-notice, the License shall be in default and shall be subject to immediate termination.

13. OWNERSHIP OF IMPROVEMENTS (AMD6.1 N)

All improvements, exclusive of trade fixtures, constructed or placed within the License Area by LICENSEE must, upon completion, be free and clear all liens, claims, or liability for labor or material and at COUNTY's option shall be the property of COUNTY's at the expiration of this License or upon earlier termination hereof. COUNTY retains the right to require LICENSEE, at LICENSEE's cost, to remove all LICENSEE's improvements located on the License Area at the expiration or termination hereof.

14. INSURANCE (AML10.1 N)

LICENSEE agrees to purchase all required insurance at LICENSEE's expense and to deposit with COUNTY certificates of insurance, including all endorsements required herein, necessary to satisfy COUNTY that the insurance provisions of this License have been complied with and to keep such insurance coverage and the certificates and endorsements therefore on deposit with COUNTY during the entire term of this License. This License shall automatically terminate at the same time LICENSEE's insurance coverage is terminated. If within ten (10) business days after termination under this Clause LICENSEE obtains and provides evidence of the required insurance coverage acceptable to Facilities Services Manager, this License may be reinstated at the sole discretion of Facilities Services Manager.

LICENSEE agrees that LICENSEE shall not operate on the License Area at any time the required insurance is not in full force and effect as evidenced by a certificate of insurance and necessary endorsements or, in the interim, an official binder being in the possession of Facilities Services Manager. In no cases shall assurances by LICENSEE, its employees, agents, including any insurance agent, be construed as adequate evidence of insurance. Facilities Services Manager will only accept valid certificates of insurance and

endorsements, or in the interim, an insurance binder as adequate evidence of insurance. LICENSEE also agrees that upon cancellation, termination, or expiration of LICENSEE's insurance, COUNTY may take whatever steps are necessary to interrupt any operation from or on the License Area until such time as the Facilities Services Manager reinstates the License.

If LICENSEE fails to provide Facilities Services Manager with a valid certificate of insurance and endorsements, or binder at any time during the term of the License, COUNTY and LICENSEE agree that this shall constitute a material breach of the License. Whether or not a notice of default has or has not been sent to LICENSEE, said material breach shall permit COUNTY to take whatever steps necessary to interrupt any operation from or on the License Area, and to prevent any persons, including, but not limited to, members of the general public, and LICENSEE's employees and agents, from entering the License Area until such time as Facilities Services Manager is provided with adequate evidence of insurance required herein. LICENSEE further agrees to hold COUNTY harmless for any damages resulting from such interruption of business and possession, including, but not limited to, damages resulting from any loss of income or business resulting from the COUNTY's action.

All contractors performing work on behalf of LICENSEE pursuant to this License shall obtain insurance subject to the same terms and conditions as set forth herein for LICENSEE. LICENSEE shall not allow contractors or subcontractors to work if contractors have less than the level of coverage required by COUNTY from LICENSEE under this License. It is the obligation of LICENSEE to provide written notice of the insurance requirements to every contractor and to receive proof of insurance prior to allowing any contractor to begin work within the License Area. Such proof of insurance must be maintained by LICENSEE through the entirety of this License and be available for inspection by a COUNTY representative at any reasonable time.
All self-insured retentions (**"SIRs"**) and deductibles shall be clearly stated on the Certificate of Insurance. If no SIRs or deductibles apply, indicate this on the Certificate of Insurance with a "0" by the appropriate line of coverage. Any **SIR** or deductible in excess of $25,000 ($5,000 for automobile liability), shall specifically be approved by COUNTY's Risk Manager.

If LICENSEE fails to maintain insurance acceptable to COUNTY for the full term of this License, COUNTY may terminate this License.

Qualified Insurer

The policy or policies of insurance must be issued by an insurer licensed to do business in the state of California (California Admitted Carrier) or have a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category) as determined by the most current edition of the **Best's key Rating Guide/Property-Casualty/United States or ambest.com**.

If the insurance carrier is not an admitted carrier in the state of California and does not have an A.M. Best rating of A-/VIII, COUNTY's Risk Manager retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by LICENSEE shall provide the minimum limits and coverage as set forth below:

Coverages	Minimum Limits

Coverages	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence $2,000,000 aggregate
Automobile Liability including coverage for owned, non-owned and hired vehicles	$1,000,000 limit per occurrence
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (**"ISO"**) form CG 00 01, or a substitute form providing liability coverage at least as broad.
The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing liability coverage as broad.

Required Endorsements

The following endorsements must be submitted with the Certificate of Insurance:

a) The Commercial General Liability policy shall contain an Additional Insured endorsement using ISO form CG 2010 or CG 2033 or a form at least as broad naming the COUNTY, its elected and appointed officials, officers, employees, and agents as Additional Insureds.

b) The Commercial General Liability policy shall contain a primary non-contributing endorsement evidencing that the LESSEE's insurance is primary and any insurance or self-insurance maintained by the COUNTY shall be excess and non-contributing.

c) The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the COUNTY, and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees.

d) The Commercial Property policy shall contain a Loss Payee endorsement naming the COUNTY as respects the COUNTY's financial interest when applicable.

All insurance policies required by this contract shall waive all rights of subrogation against the COUNTY and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

All insurance policies required by this contract shall give COUNTY thirty (30) days notice in the event of cancellation and ten (10) days for non-payment of premium. This shall be evidenced by policy provisions or an endorsement separate from the Certificate of Insurance.

The Commercial General Liability policy shall contain a severability of interests' clause, also known as a "separation of insureds" clause (standard in the ISO CG 001 policy).

Insurance certificates should be forwarded to COUNTY's address provided in Clause 17 (NOTICES) below or to an address provided by SSA/Facilities Services Manager. LICENSEE has ten (10) business days to provide adequate evidence of insurance or this License may be cancelled.

COUNTY expressly retains the right to require LICENSEE to increase or decrease insurance of any of the above insurance types throughout the term of this License. Any increase or decrease in insurance will be as deemed by COUNTY's Risk Manager as appropriate to adequately protect COUNTY.

COUNTY shall notify LICENSEE in writing of changes in the insurance requirements. If LICENSEE does not deposit copies of acceptable certificates of insurance and endorsements with COUNTY incorporating such changes within thirty (30) days of receipt of such notice, this License may be in breach without further notice to LICENSEE, and COUNTY shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit LICENSEE's liability hereunder nor to fulfill the indemnification provisions and requirements of this License, nor in any way to reduce the policy coverage and limits available from the insurer.

15. OPERATIONS (AMLC-11.1 N)

LICENSEE shall keep and maintain the License Area and all improvements of any kind in good condition and in substantial repair. COUNTY will, on LICENSEE's behalf, provide all maintenance and repairs to the License Area during the term of the License. LICENSEE is required to notify COUNTY of any and all necessary maintenance and repairs to the License Area on a timely basis.

LICENSEE expressly agrees to maintain the License Area in a safe, clean, wholesome, and sanitary condition, to the complete satisfaction of COUNTY and in compliance with all applicable laws. LICENSEE further agrees to keep the License Area free and clear of rubbish and litter. COUNTY shall have the right to enter upon and inspect the License Area at any time for cleanliness and safety.

LICENSEE shall designate in writing to COUNTY an on-site representative who shall be responsible for the day to day operation and level of maintenance, cleanliness, and general order.

16. LIMITATION OF THE LICENSE (AMLC-13.1 S)

This License and the rights and privileges granted LICENSEE in and to the License Area are subject to all covenants, conditions, restrictions, and exceptions of record or apparent from a physical inspection of the License Area. Nothing contained in this License or in any document related hereto shall be construed to imply the conveyance to LICENSEE of rights in the License Area, which exceed those owned by COUNTY.

17. HIPAA NOTICE (N)

LICENSEE acknowledges that the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) requires COUNTY to safeguard and maintain the confidentiality of any Protected Health Information (PHI). LICENSEE hereby agrees not to access, remove, destroy, or relocate any property used by COUNTY to safeguard and store PHI. LICENSEE further agrees to use appropriate safeguards and to

take all reasonable steps to prevent access to any PHI stored on the premises, including informing its workforce, contractors and vendors of the confidential nature of the records maintained by COUNTY. LICENSEE agrees to report to COUNTY within ten (10) calendar days any unauthorized use or any disclosure of PHI, which LICENSEE becomes aware. Upon COUNTY's knowledge of any breach, disclosure, or unauthorized use of PHI by LICENSEE, COUNTY shall:

a. Provide an opportunity for LICENSEE to cure the breach or end the violation. If LICENSEE does not cure the breach or end the violation within thirty (30) days or shorter period as required by COUNTY, COUNTY shall terminate this Agreement; or

b. Immediately terminate this Agreement if cure is not possible.

18. HAZARDOUS MATERIALS (AMLC-16.1 S)

A. Definition of Hazardous Materials. For purposes of this License, the term **"Hazardous Material"** or "Hazardous Materials" shall mean any hazardous or toxic substance, material, product, byproduct, or waste which is or shall become regulated by any governmental entity, including, without limitation, the COUNTY acting in its governmental capacity, the State of California or the United States government.

B. Use of Hazardous Materials. LICENSEE or LICENSEE's employees, agents, independent contractors or invitees (collectively **"LICENSEE Parties"**) shall not cause or permit any Hazardous Materials to be brought upon, stored, kept, used, generated, released into the environment or disposed of on, under, from or about the License Area (which for purposes of this clause shall include the subsurface soil and ground water). Notwithstanding the foregoing, LICENSEE may keep on or about the License Area small quantities of Hazardous Materials that are used in the ordinary, customary and lawful cleaning of and business operations on the License Area.

C. LICENSEE Obligations. If the presence of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties results in (i) injury to any person, (ii) injury to or contamination of the License Area (or a portion thereof), or (iii) injury to or contamination or any real or personal property wherever situated, LICENSEE, at its sole cost and expense, shall promptly take all actions necessary or appropriate to return the License Area to the condition existing prior to the introduction of such Hazardous Materials to the License Area and to remedy or repair any such injury or contamination. Without limiting any other rights or remedies of COUNTY under this License, LICENSEE shall pay the cost of any cleanup or remedial work performed on, under, or about the License Area as required by this License or by applicable laws in connection with the removal, disposal, neutralization or other treatment of such Hazardous Materials caused or permitted by LICENSEE or LICENSEE Parties. Notwithstanding the foregoing, LICENSEE shall not take any remedial action in response to the presence, discharge or release, of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties, or enter into any settlement agreement, consent decree or other compromise with any governmental or quasigovernmental entity without first obtaining the prior written consent of the COUNTY. All work performed or caused to be performed by LICENSEE as provided for above shall be done in good and workmanlike manner and in compliance with plans, specifications, permits and other requirements for such work approved by COUNTY.

D. Indemnification for Hazardous Materials. To the fullest extent permitted by law, LICENSEE hereby agrees to indemnify, hold harmless, protect and defend (with attorneys acceptable to COUNTY) COUNTY, its elected officials, officers, employees, agents and independent contractors and the

License Area, from and against any and all liabilities, losses, damages (including, but not limited, damages for the loss or restriction on use of rentable or usable space or any amenity of the License Area or damages arising from any adverse impact on marketing of the License Area), diminution in the value of the License Area, judgments, fines, demands, claims, recoveries, deficiencies, costs and expenses (including, but not limited to, reasonable attorneys' fees, disbursements and court costs and all other professional or consultant's expenses), whether foreseeable or unforeseeable, arising directly or indirectly out of the presence, use, generation, storage, treatment, on or off-site disposal or transportation of Hazardous Materials on, into, from, under or about the License Area by LICENSEE or LICENSEE's Parties. The foregoing indemnity shall also specifically include the cost of any required or necessary repair, restoration, clean-up or detoxification of the License Area and the preparation of any closure or other required plans.

19. NOTICES (AMLC-14.1 S)

All notices pursuant to this License shall be addressed as set forth below or as either Party may hereafter designate by written notice and shall be sent through the United States mail in the State of California duly registered or certified with postage prepaid. If any notice is sent by registered or certified mail, as aforesaid, the same shall be deemed served or delivered twenty-four (24) hours after mailing thereof as above provided. Notwithstanding the above, COUNTY may also provide notices to LICENSEE by personal delivery, by regular mail, or by electric mail and any such notice so given shall be deemed to have been given upon receipt.

TO: COUNTY

County of Orange
Social Services Agency
Facilities Services
500 N. State College Boulevard
Orange, CA 92868

With a copy to:

County Executive Office
Attention: Chief Real Estate Officer
333 W. Santa Ana Boulevard, 3rd Floor
Santa Ana, CA 92701

TO: LICENSEE

CalOptima
15496 Magnolia, #111
Westminster, CA 92806
Phil Tsunoda, Executive Director,
Public Policy & Public Affairs
ptsunoda@caloptima.org

20. ATTACHMENTS TO LICENSE (AMLC-15.1 S)

This License includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
Exhibit A - License Description
Exhibit B – Floor Plan

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WITNESS WHEREOF, the parties have executed this License the day and year first above written.

APPROVED AS TO FORM:
OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By_____
Deputy County Counsel

Date:_____

LICENSEE
CalOptima

By_____

Name:_____
Title:_____

RECOMMENDED FOR APPROVAL

Social Services Agency

By_____
Carol Wiseman, Chief Deputy Director

CEO Real Estate Services

By_____
John Beck, Administrative Manager

COUNTY

COUNTY OF ORANGE

By _____
Scott Mayer, Chief Real Estate Officer
County Executive Office
Per Resolution No. 14-014 of the Board of Supervisors and Minute Order dated January 28, 2014

Date:_____

GENERAL CONDITIONS (AMLC-GC l-17 S)

1. PERMITS AND LICENSES (AMLC - GC2 S)

LICENSEE shall be required to obtain any and all permits and/or licenses which may be required in connection with the operation of the License Area as set out herein. No permit, approval, or consent given hereunder by COUNTY, in its governmental capacity, shall affect or limit LICENSEE's obligations hereunder, nor shall any approvals or consents given by COUNTY, as a Party to this License, be deemed approval as to compliance or conformance with applicable governmental codes, laws, rules, or regulations.

2. SIGNS (AMLC-GC3 S)

LICENSEE agrees not to construct, maintain, or allow any signs, banners, flags, etc., upon License Area except as approved by Facilities Operations Manager unapproved signs, banners, flags, etc., may be removed.

3. LICENSE ORGANIZATION (AMLC-GC4 S)

The various headings and numbers herein, the grouping of provisions of this License into separate clauses and paragraphs, and the organization hereof, are for the purpose of convenience only and shall not be considered otherwise.

4. AMENDMENTS (AMLC-GC5 S)

This License is the sole and only agreement between the Parties regarding the subject matter hereof; other agreements, either oral or written, are void. Any changes to this License shall be in writing and shall be properly executed by both Parties.

5. UNLAWFUL USE (AMLC-GC6 S)

LICENSEE agrees no improvements shall be erected, placed upon, operated, nor maintained on the License Area, nor any business conducted or carried on therein or there from, in violation of the terms of this License, or of any regulation, order of law, statute, bylaw, or ordinance of a governmental agency having jurisdiction.

6. INSPECTION (AMLC-GC7 S)

COUNTY or its authorized representative shall have the right at all reasonable times to inspect the operation to determine if the provisions of this License are being complied with.

7. INDEMNIFICATION (AMLC-GC8 S)

LICENSEE hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of persons or property arising from, growing out of, or in any way connected with or related to this License except claims arising from the concurrent active or sole negligence of COUNTY, its officers, agents, and employees. LICENSEE hereby agrees to indemnify, hold harmless, and defend with counsel acceptable to COUNTY, its officers, agents, and employees against any and all claims, loss, demands, damages, cost, expenses, or liability costs arising out of the operation, use, or maintenance of the property

described herein, and/or LICENSEE's exercise of the rights under this License, except for liability arising out of the concurrent active or sole negligence of COUNTY, its officers, agents, or employees, including the cost of defense of any lawsuit arising there from.

In the event COUNTY is named as co-defendant, LICENSEE shall notify COUNTY of such fact and shall represent COUNTY with counsel acceptable to COUNTY in such legal action unless COUNTY undertakes to represent itself as co-defendant in such legal action, in which event LICENSEE shall pay to COUNTY its litigation costs, expenses, and attorney's fees. In the event judgment is entered against COUNTY and LICENSEE because of the concurrent active negligence of COUNTY and LICENSEE, their officers, agents, or employees, an apportionment of liability to pay such judgment shall be made by a court of competent jurisdiction. Neither Party shall request a jury apportionment.

8. TAXES AND ASSESSMENTS (AMLC-GC9 S)

Although not anticipated, should this License create a possessory interest which is subject to the payment of taxes levied on such interest, it is understood and agreed that all taxes and assessments (including but not limited to said possessory interest tax) which become due and payable in connection with this License or upon fixtures, equipment, or other property used in connection with this License, shall be the full responsibility of LICENSEE, and LICENSEE shall cause said taxes and assessments to be paid promptly.

9. PARTIAL INVALIDITY (AMLC-GC10 S)

If any term, covenant, condition, or provision of this License is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

10. WAIVER OF RIGHTS (AMLC-GC11 S)

The failure of COUNTY to insist upon strict performance of any of the terms, covenants, or conditions of this License shall not be deemed a waiver of any right or remedy that COUNTY may have, and shall not be deemed a waiver of the right to require strict performance of all the terms, covenants, and conditions of the License thereafter, nor a waiver of any remedy for the subsequent breach or default of any term, covenant, or condition of the License. Any waiver, in order to be effective, must be signed by the Party whose right or remedy is being waived.

11. CONDITION OF LICENSE AREA UPON TERMINATION (AMLC-GC12 S)

Except as otherwise agreed to herein, upon termination of this License, LICENSEE shall redeliver possession of said License Area to COUNTY in substantially the same condition that existed immediately prior to LICENSEE’s entry thereon, reasonable wear and tear, flood, earthquakes, and any act of war excepted.

12. DISPOSITION OF ABANDONED PERSONAL PROPERTY (AMLC-GC13 S)

If LICENSEE abandons the License Area or is dispossessed thereof by process of law or otherwise, title to any personal property belonging to LICENSEE and left on the License Area ten (10) days after such event shall be deemed, at COUNTY’s option, to have been transferred to COUNTY. COUNTY shall have the

right to remove and to dispose of such property without liability there from to LICENSEE or to any person claiming under LICENSEE, and shall have no need to account therefore.

13. TIME OF ESSENCE (AMLC-GC14 S)

Time is of the essence of this License. Failure to comply with any time requirements of this License shall constitute a material breach of this License.

14. NO ASSIGNMENT (AMLC-G15 S)

The License granted hereby is personal to LICENSEE and any assignment of said license by LICENSEE, voluntarily or by operation of law, shall automatically terminate the License granted hereby.

15. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (AMLC-GC16 S)

In order to comply with child support requirements of the County of Orange, LICENSEE hereby furnishes COUNTY's Facilities Operations Manager, COUNTY's standard form, Child Support Enforcement Certification Requirements. COUNTY acknowledges receipt of the aforementioned form, which contains the following information:

a) In the case where LICENSEE is doing business as an individual, LICENSEE's name, date of birth, Social Security number, and residence address;

b) In the case where LICENSEE is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;

c) A certification that LICENSEE has fully complied with all applicable federal and state reporting requirements regarding its employees; and

d) A certification that LICENSEE has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment and will continue to so comply.

Failure of LICENSEE to continuously comply with all federal and state reporting requirements for child support enforcement or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment shall constitute a material breach of this License. Failure to cure such breach within sixty (60) calendar days of notice from COUNTY's shall constitute grounds for termination of this License.

It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders and will not be used for any other purpose.

16. RIGHT TO WORK AND MINIMUM WAGE LAWS (AMLC-GC17 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LICENSEE shall require its employees that directly or indirectly service the License Area or terms and conditions of this License, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LICENSEE shall also require and verify that its contractors or any other persons servicing the License Area

or terms and conditions of this License, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LICENSEE shall pay no less than the greater of the Federal or California Minimum Wage to all its employees that directly or indirectly service the License Area, in any manner whatsoever. LICENSEE shall require and verify that all its contractors or other persons servicing the License Area on behalf of LICENSEE also pay their employees no less than the greater of the Federal or California Minimum Wage.

LICENSEE shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the License Area or terms and conditions of this License.

Notwithstanding the minimum wage requirements provided for in this clause, LICENSEE, where applicable, shall comply with the prevailing wage and related requirements pursuant to the provisions of Section 1773 of the Labor Code of the State of California.

17. BEST MANAGEMENT PRACTICES (AMLC 15.1 S)

LICENSEE and all of LICENSEE's, agents, employees and contractors shall conduct operations under this License so as to assure that pollutants do not enter municipal storm drain systems which systems are comprised of, but are not limited to curbs and gutters that are part of the street systems ("**Stormwater Drainage System**"), and to ensure that pollutants do not directly impact "**Receiving Waters**" (as used herein, Receiving Waters include, but are not limited to, rivers, creeks, streams, estuaries, lakes, harbors, bays and oceans).

The Santa Ana and San Diego Regional Water Quality Control Boards have issued National Pollutant Discharge Elimination System ("**NPDES**") permits ("**Stormwater Permits**") to the County of Orange, and to the Orange County Flood Control District and cities within Orange County, as co-permittees (hereinafter collectively referred to as "**County Parties**") which regulate the discharge of urban runoff from areas within the County of Orange, including the License Area. The County Parties have enacted water quality ordinances that prohibit conditions and activities that may result in polluted runoff being discharged into the Stormwater Drainage System.

To assure compliance with the Stormwater Permits and water quality ordinances, the County Parties have developed a Drainage Area Management Plan ("**DAMP**") which includes a Local Implementation Plan ("**LIP**") for each jurisdiction that contains Best Management Practices ("**BMP(s)**") that parties using properties within Orange County must adhere to. As used herein, a BMP is defined as a technique, measure, or structural control that is used for a given set of conditions to manage the quantity and improve the quality of stormwater runoff in a cost effective manner. These BMPs are found within the COUNTY's LIP in the form of Model Maintenance Procedures and BMP Fact Sheets (the Model Maintenance Procedures and BMP Fact Sheets contained in the DAMP/LIP shall be referred to hereinafter collectively as "**BMP Fact Sheets**") and contain pollution prevention and source control techniques to eliminate non-stormwater discharges and minimize the impact of pollutants on stormwater runoff.

The use under this License does not require BMP Fact Sheets.

18. PAYMENT CARD COMPLIANCE (AMLC-G15 S)

Should LICENSEE conduct credit/debit card transactions in conjunction with their business with the COUNTY, on behalf of the COUNTY, or as part of the business that they conduct, LICENSEE covenants and warrants that it is currently Payment Card Industry Data Security Standard (**"PCI DSS"**) and Payment Application Data Security Standards (**"PA DSS"**) compliant and will remain compliant during the entire duration of this License. LICENSEE agrees to immediately notify COUNTY in the event LICENSEE should ever become non-compliant, and will take all necessary steps to return to compliance and shall be compliant within ten (10) days of the commencement of any such interruption.

Upon demand by COUNTY, LICENSEE shall provide to COUNTY written certification of LICENSEE's PCI DSS and/or PA DSS compliance.

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//

LICENSE DESCRIPTION (10.1 S)

PROJECT NO: GA 1213-236 DATE: 6/29/16

PROJECT: CalOptima
15496 Magnolia, #111
Westminster, CA 92806

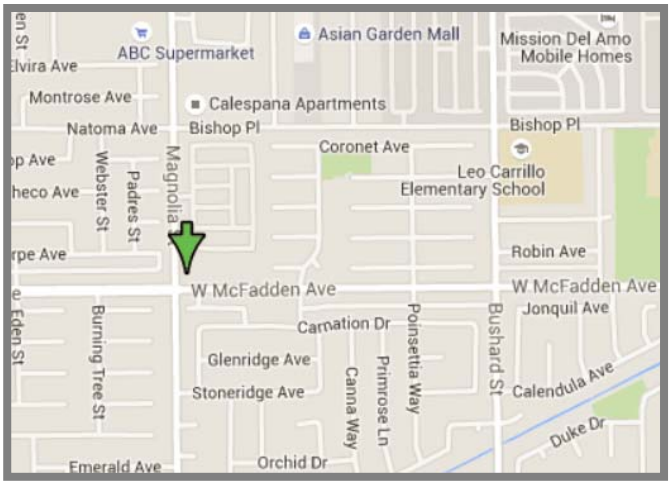
WRITTEN BY: EAS

All the License Area referenced on a Floor Plan marked Exhibit B, attached hereto and made a part hereof, being approximately Three Hundred Sixty Two (362) rentable square feet of COUNTY-designated space for LICENSEE's non-exclusive use, which space may vary from time-to-time based on COUNTY's pre-approval in writing, and being a portion of the Orange County Community Service Center Annex building located at 15496 Magnolia, Suite 111, Rooms 1 and 2 in the City of Westminster, County of Orange, State of California, together with appurtenant right to use common areas located thereon, and the non-exclusive use of one parking space in the adjacent parking lot.

NOT TO BE RECORDED

EXHIBIT A

GA 1213-237
SSA/CalOptima



Location Map

License Area:
Rooms 1 & 2

EXHIBIT B

Reception Area

CCSC COST APPLY - 15496 Magnolia Street, Westminster

FY 2016-17 MONTHLY INVOICE CODING SUMMARY

Invoice Coding and Job Number Allocation.

	Fund/Dept/Budget Control Unit/Object/Job No.	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency/Partners	100/063/063 2211/2200/ S34000	$ 656.94	$ 295.21	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	**$ 12,117.85**
Clerk-Recorder	100/063/063 2211/2200/ S34006	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Health Care Agency	100/063/063 2211/2200/ S34007	$ 1,278.26	$ 1,278.26	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	**$ 46,212.65**
OC Community Resources	100/063/063 2211/2200/ S34008	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
CalOptima	100/063/063 2211/2200/S34009	$ -	$ 361.73	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	**$ 14,891.90**
		$ 1,935.20	**$ 1,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 73,222.40**

LEASED SPACE

	sq ft	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency	**177.25**	**16.43%**	**$ 251.40**	**$ 107.96**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 9,652.58**
Health Care Agency - Total	**666.25**	**61.75%**	**$ 405.80**	**$ 405.80**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 35,743.11**
- Environmental Health	379.05	35.13%	$ 230.87	$ 230.87	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	20,335.35
- AMHS	232.7	21.57%	$ 141.73	$ 141.73	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	12,483.93
- Public Health Nursing	54.5	5.05%	$ 33.19	$ 33.19	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	2,923.83
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**235.5**	**21.83%**	**$ -**	**$ 143.44**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 12,490.71**
					$ -										
TOTAL	**1079**	**100%**	**$ 657.20**	**$ 657.20**	**$ 5,000.00**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 57,886.40**

Total leased space: 2080 sq. ft.

Lease rates:	Monthly	Fiscal Year total:
Rent: September 1, 2016 - September 30, 2017	$ 5,000.00	$ 50,000.00
Operating Expenses: July 1 2016- June 30, 2017	$ 657.20	$ 7,886.40

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IT SERVICES

	# computers	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency	**1**	**12.50%**	**$ 96.25**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 625.63**
Health Care Agency - Total	**6**	**75.00%**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 3,465.00**
- Environmental Health	5	$ 0.63	$ 240.63	$ 240.63	240.625	240.625	240.625	240.625	240.625	240.625	240.625	240.625	240.625	240.625	$ 2,887.50
- AMHS	0.5	$ 0.06	$ 24.06	$ 24.06	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	$ 288.75
- Public Health Nursing	0.5	$ 0.06	$ 24.06	$ 24.06	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	$ 288.75
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**1**	**12.50%**	**$ -**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 529.38**
TOTAL	**8**	**100%**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 4,620.00**

Monthly IT rates	$ 385.00
Annual Telephone Service Costs	$ 4,620.00

TELEPHONE SERVICES

	# phones	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency	**1**	**16.67%**	**$ 39.33**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 255.67**
Health Care Agency - Total	**4**	**66.67%**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 944.00**
- Environmental Health	3	50.00%	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 708.00
- AMHS	0.5	8.33%	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 118.00
- Public Health Nursing	0.5	8.33%	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 118.00
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**1**	**16.67%**	**$ -**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 216.33**
TOTAL	**6**	**100%**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 1,416.00**

Monthly Telephone Service Costs	$ 118.00
Annual Telephone Service Costs	$ 1,416.00

JANITORIAL SERVICES

	sq ft	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total

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Social Services Agency	**177.25**	**16.43%**	**$**	**219.95**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**1,258.98**
Health Care Agency - Total	**666.25**	**61.75%**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**4,260.54**
- Environmental Health	379.05	35.13%	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	2,423.95
- AMHS	232.7	21.57%	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	1,488.07
- Public Health Nursing	54.5	5.05%	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	348.52
Clerk-Recorder	**0**	**0.00%**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**
OC Community Resources - Total	**0**	**0.00%**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**
Cal Optima	**235.5**	**21.83%**	**$**	**-**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**1,380.48**
TOTAL	**1079**	**100%**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**6,900.00**

Total leased space: 2080 sq. ft.

Monthly Janitorial Costs $ 575.00
12 mo. Annual Janitorial Costs $ 6,900.00

ELECTRICAL/UTILITIES

	sq ft	Allocation %	219.9548193	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	Annual Total
Social Services Agency	**1**	**12.50%**	**$ 50.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 325.00**
Health Care Agency - Total	**6**	**75.00%**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 1,800.00**
- Environmental Health	5	62.50%	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 1,500.00
- AMHS	0.5	6.25%	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 150.00
- Public Health Nursing	0.5	6.25%	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 150.00
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**1**	**12.50%**	**$ -**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 275.00**
TOTAL	**8**	**100%**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 2,400.00**

Total leased space: 2080 sq. ft.

Estimated Utility Costs $ 200.00
12 mo. Annual Janitorial Costs $ 2,400.00

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Annex - 15496 Magnolia Ave, CCSC

Previous site amount	Variance
$ 11,476.51	$34,736.14

Total Annual Charges - check

$ 70,822.40

CODING

SSA INVOICE				Cost Apply - Other Agency			
Fund/Dept/Budget Control	Unit	Object	Job #	Fund/Dept/Budget Control	Unit	Object	Job #
100/063/063	2211	2200	S34000	--	--	--	--
100/063/063	2211	2200	S34007	See below			
See above				100/042/042	6600	2200	H4046800
See above				100/042/042	2100	2200	H2407N70
See above				100/042/042	1520	2200	H1120800
100/063/063	2211	2200	S34006	100/059/059	--	2200	PCW002
100/063/063	2211	2200	S34008	See below			
	2211	2200	S34009	NA - will be invoiced			
Default SSA coding	--	--	--	--	--	--	--
100/063/063	2211	2200	S34000	--	--	--	--

Lease, Janitorial & Utility Allocation	sq ft	Allocation %
Social Services Agency	177.25	16.427%
Health Care Agency	666.25	61.747%
- Environmental	379.05	35.130%
- AMHS	232.7	21.566%
- Public Health	54.5	5.051%
Clerk-Recorder	0	0.000%
OC Community Resources	0	0.000%
CalOptima	235.5	21.826%
TOTAL	1079	161.7%

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West Annex Community Customer Service Center
15496 Magnolia Street
Westminster, CA 92683

LEASE

THIS IS A LEASE (hereinafter referred to as "**Lease**"), made July 1, 2016, ("**Effective Date**") by and between CHARLES H. MANH and ANH MANH, Co-Trustees of the MANH FAMILY TRUST, under declaration of trust dated August 15, 2006 ("**LESSOR**") and the COUNTY OF ORANGE, a political subdivision of the State of California ("**COUNTY**"), without regard to number and gender. The LESSOR and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**.

1. DEFINITIONS (1.2 S)

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

"CEO Real Estate"" means the County Executive Office's Real Estate team, or upon written notice to LESSOR, such other person or entity as shall be designated by the Chief Real Estate Officer, County of Orange, or designee.

"Chief Real Estate Officer" means the Chief Real Estate Officer for the County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or r the Board of Supervisors.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

"Risk Manager" means the Risk Manager, County Executive Office, Risk Management, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. PREMISES (1.3 S)

LESSOR leases to COUNTY that certain property consisting of 2,120 square feet, located at 15496 Magnolia Street, Suite 111, Westminster, CA and described in Exhibit A and shown on Exhibit B, which exhibits are attached hereto and by reference made a part hereof (hereinafter referred to as "**Premises**"),, together with non-exclusive, in common use of LESSOR's elevators, stairways, washrooms, hallways, parking areas, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to the Premises created by this Lease.

3. PARKING (1.4 S)

LESSOR, throughout the term of this Lease, shall provide a total of thirteen (13) parking spaces for COUNTY's free and non-exclusive use. Said parking spaces are to be located in the parking areas adjacent to the Premises. LESSOR shall designate three (3) parking spaces adjacent to the Premises to be reserved for use by COUNTY clients. Said parking spaces shall contain signs above the space indicating that the spaces are reserved for COUNTY use.

In addition to said parking spaces, LESSOR shall also provide parking for disabled persons in accordance with the Americans with Disabilities Act, Section 7102 of the California Uniform Building Code and the applicable codes and/or ordinances relating to parking for disabled persons as established by the local jurisdiction in which the Premises is located where the provisions of such local codes and/or ordinances exceed or supersede the State requirements.

4. TERM (2.2 N)

The term of this Lease shall be one (1) year ("**Term**"), commencing upon the first of the next month following execution of this Lease by the COUNTY Chief Real Estate Officer or upon LESSOR's delivery and COUNTY's acceptance of the Premises, whichever is later ("**Commencement Date**").
Parties agree that the Commencement Date of this Lease will be confirmed in writing by either Party upon demand by the other.

5. RENT (3.1 N)

COUNTY agrees to pay LESSOR as rent for the Premises the sum of Five Thousand Dollars ($5,000.00) per month pursuant to the following rent payment schedule ("**Rent**").

MONTH	MONTHLY RENT	MONTH	MONTHLY RENT
1	$0.00	7	$5,000.00
2	$0.00	8	$5,000.00
3	$5,000.00	9	$5,000.00
4	$5,000.00	10	$5,000.00
5	$5,000.00	11	$5,000.00
6	$5,000.00	12	$5,000.00

To obtain rent payments LESSOR (or LESSOR's designee) shall submit to the COUNTY, in a form acceptable to said COUNTY, a written claim for payment of applicable Rent and COUNTY's share of the NNN Expenses, as defined in Section 6, below.

Payment shall be due and payable by direct deposit into a bank account specified by LESSOR within twenty (20) days after the later of the following:

A. The first day of the month following the month earned; or
B. Receipt of LESSOR's written claim by COUNTY.

Should COUNTY occupy the Premises before the Commencement Date, LESSOR shall be entitled to pro rata Rent for the period of occupancy occupied prior to the Commencement Date based upon the monthly Rent above. Said Rent shall be included in the rent claim submitted by LESSOR for the first full month of the Term and shall be paid by COUNTY at the time of payment for said month.

6. REIMBURSEMENT OF LESSOR'S OPERATING EXPENSES (6.0 N)

LESSOR and COUNTY agree pursuant to Section 5, above, that COUNTY shall pay the fixed amount of $657.20 ($.31/sf/mo.) per month for the term of the lease, as reimbursement for COUNTY's pro rata share of LESSOR's expenses related to the items described in Section 6A, 6B, 6C and 6D of this Lease for the property in which the Premises is located ("**NNN Expenses**"). LESSOR shall submit to COUNTY a separate monthly invoice .in addition to the monthly Rent invoice.

The pro rata share of LESSOR's NNN Expenses as defined above is determined according to the gross leasable area of the Premises as it relates to the total gross leasable area of the building that contains the Premises. The percent of COUNTY's occupancy which LESSOR and COUNTY agree is 12.47% (the "**pro rata share**"): the Premises is 2,120 gross square feet; and the total building area is 17,000 gross square feet.

COUNTY shall reimburse LESSOR for COUNTY's pro rata share of the NNN Expenses only for the items in Section 6A, 6B and 6C and 6D below:

A. Property Taxes and Property Tax Assessments pursuant to Section 13 of this Lease.
B. Maintenance and repair, and janitorial services for the common area restrooms in the building in which the Premises is located pursuant to Section 9 of this Lease.
C. Common area maintenance and repair of the building, parking lots, landscaping, lighting, and other common area maintenance and repair costs pursuant to Section 9 of this Lease.
D. Commercial Property Insurance and Commercial General Liability Insurance pursuant to Section 11 of this Lease.

7. ALTERATIONS (4.4 S)

COUNTY may make improvements and changes in the Premises, including but not limited to the installation of fixtures, partitions, counters, shelving, and equipment as deemed necessary or appropriate. It is agreed that any such fixtures, partitions, counters, shelving, or equipment attached to or placed upon the Premises by COUNTY shall be considered as personal property of COUNTY, who shall have the right to remove same. COUNTY agrees that the Premises shall be left in as good condition as when received, reasonable wear and tear excepted.

8. ORANGE COUNTY INFROMATION TECHNOLOGY SYSTEM S (OCIT) (4.5 N)

LESSOR agrees that COUNTY may install, at COUNTY's sole cost and expense, computer and telecommunication devices in, on, or around the Premises and LESSOR's building in accordance with COUNTY's plans and specifications provided that the provisions of the Clause entitled ALTERATIONS, of this Lease, shall be applicable to such work. It shall be COUNTY's responsibility to obtain all governmental permits and/or approvals required for such installation; however, LESSOR shall reasonably cooperate with COUNTY as necessary or appropriate, to obtain said permits and/or approvals.

9. REPAIR, MAINTENANCE, AND JANITORIAL SERVICES (5.1 N)

LESSOR shall keep, maintain, and repair the building and other improvements upon the Premises in good and sanitary order and condition (except as otherwise provided in this Lease) including without limitation, the maintenance and repair of the roof, parking lot, sidewalks, common area restrooms including janitorial supplies and services, landscaping, store front, doors, window casements, glazing, plumbing, pipes, electrical wiring, and conduits, and the heating and air conditioning system including the maintenance of a service contract with a heating and air conditioning contractor, as necessary to maintain the property in

which the Premises is located in good and sanitary order, condition, and repair. COUNTY shall reimburse LESSOR for the County's pro rata share of said expenses in accordance with Section 6 of the Lease. Notwithstanding the language in the paragraph above, COUNTY shall provide at its own cost and expense all repair and maintenance and services to the interior of the Premises.

A. Heating, Ventilation and Air Conditioning System (HVAC)

During all operating hours the HVAC system serving the Premises, to be repaired and maintained by the LESSOR, shall be capable of maintaining the Premises at 78º Dry Bulb at a maximum range of 40% to 60% Relative humidity during the summer when the outdoor temperature is 95º Dry Bulb, and at 68º Dry Bulb in the winter when the outside temperature is 35º Dry Bulb.

In order for the COUNTY to comply with the California Code of Regulations, Title 8, Section 5142, and as it may be subsequently amended, LESSOR shall inspect the HVAC system at least once annually or on a schedule agreed to in writing by LESSOR and COUNTY, and provide repair and maintenance accordingly. LESSOR's inspections and maintenance of the HVAC system shall be documented in writing. The LESSOR shall at a minimum, maintain a record of: (a) the name of the individual(s) inspecting and/or maintaining the system, (b) the date of the inspection and/or maintenance, and (c) the specific findings and actions taken. The LESSOR shall ensure that such records are retained for at least five (5) years. The LESSOR shall make all HVAC records required by this section available to COUNTY for examination and copying, within forty-eight (48) hours of a written request from COUNTY. LESSOR acknowledges that COUNTY may be subject to fines and/or penalties for failure to provide said records to regulatory agencies within the given timeframes. Should COUNTY incur fines and/or penalties as a direct result of LESSOR's failure to provide said records to COUNTY, LESSOR shall reimburse COUNTY for said fines and/or penalties within thirty (30) days upon written notice. Should LESSOR fail to reimburse COUNTY within thirty (30) days, COUNTY may deduct the amount of the fine and/or penalty from any rent payable.

B. Janitorial Supplies and Services

LESSOR shall provide janitorial supplies and services on a five-day-per-week basis (Monday through Friday) to the common areas and common area restrooms in accordance with Exhibit D (JANITORIAL SPECIFICATIONS) attached hereto and by reference made a part hereof.

If LESSOR fails to provide satisfactory janitorial supplies to Premises, the Chief Real Estate Officer, or designee may notify LESSOR either verbally or in writing; and if LESSOR does not provide janitorial supplies within twenty-four (24) hours after LESSOR has received such written notice from COUNTY, COUNTY may provide the janitorial supplies necessary or have others do

so, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

If LESSOR or its representative cannot be contacted by COUNTY for emergency repairs and/or services the same day any emergency repairs and/or services are necessary to remedy the emergency condition, or if LESSOR following such contact by COUNTY is unable or refuses to make the necessary repairs within a reasonable time or provide the necessary services, as determined by the Chief Real Estate Officer, COUNTY may at its option have the necessary repairs made and/or provide services to remedy the emergency condition, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

10. ELECTRIC UTILITIES (5.2 N)

COUNTY shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the interior of the Premises directly to the utility company.

LESSOR shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the exterior of the Premises and to the common areas of the property in which the Premises is located.

INSURANCE (5.3 S)

Commercial Property Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial property insurance with all risk or special form coverage, covering the loss or damage to the Premises to the full insurable value of the improvements located on the Premises (including the full value of all improvements and fixtures owned by LESSOR) at least in the amount of the full replacement cost thereof, and in no event less than the total amount required by any lender holding a security interest.

LESSOR agrees to and shall include in the policy or policies of commercial property insurance a standard waiver of the right of subrogation against COUNTY by the insurance company issuing said policy or policies. LESSOR shall provide COUNTY with a Certificate of Insurance as evidence of compliance with these requirements.

Commercial General Liability Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial general liability insurance covering all injuries occurring

within the building and the Premises. The policy or policies evidencing such insurance shall provide the following:

a. Name COUNTY as an additional insured;
b. Shall be primary, and any insurance or self-insurance maintained by COUNTY shall be excess and non-contributing;
c. LESSOR shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the Lease, upon which the County may suspend or terminate this Lease.
d. Shall provide a limit of One Million Dollars ($1,000,000) per occurrence; and
e. The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings. Prior to the Commencement Date of this Lease and upon renewal of such policies, LESSOR shall submit to COUNTY a Certificate of Insurance and required endorsements as evidence that the foregoing policy or policies are in effect.

If LESSOR fails to procure and maintain the insurance required to be procured by LESSOR under this Lease, COUNTY may, but shall not be required to, order such insurance and deduct the cost thereof plus any COUNTY administrative charges from the rent thereafter payable.

11. INDEMNIFICATION (5.5 A S)

LESSOR shall defend, indemnify and save harmless COUNTY and COUNTY Parties from and against any and all claims, demands, losses, or liabilities of any kind or nature which COUNTY or the COUNTY Parties may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, or arising out of, the negligence or intentional misconduct of LESSOR or the LESSOR Parties, in connection with the maintenance or use of the Premises by LESSOR or the LESSOR Parties.

12. TAXES AND ASSESSMENTS (5.6 N)

All taxes and assessments which become due and payable upon the Premises shall be the full responsibility of LESSOR, and LESSOR shall cause said taxes and assessments to be paid prior to the due date.

COUNTY shall reimburse LESSOR for its proportionate share of Taxes and Assessments pursuant to Section 5 of this Lease.

13. BUILDING AND SAFETY REQUIREMENTS (5.7 S)

During the full term of this Lease, LESSOR, at LESSOR's sole cost, agrees to maintain the Premises in compliance with all applicable laws, rules, regulations, building codes, statutes, and orders as they are applicable on the date of this Lease, and as they may be subsequently amended.

Included in this provision is compliance with the Americans with Disabilities Act ("**ADA**") and all other federal, state, and local codes, statutes, and orders relating to disabled access as they are applicable on the dates of this Lease, and as they may be subsequently amended.

LESSOR further agrees to maintain the Premises as a "safe place of employment," as defined in the California Occupational Safety and Health Act (California Labor Code, Division 5, Part 1, Chapter 3, beginning with Section 6400) and the Federal Occupational Safety and Health Act, where the provisions of such Act exceed, or supersede, the California Act, as the provisions of such Act are applicable on the date of this Lease, and as they may be subsequently amended.

In the event LESSOR neglects, fails, or refuses to maintain said Premises as aforesaid, COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY's sole option, cure any such default by performance of any act, including payment of money, and subtract the cost thereof plus reasonable administrative costs from the rent.

14. TOXIC MATERIALS (5.9 S)

COUNTY hereby warrants and represents that COUNTY will comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "**Toxic Materials**"). COUNTY shall be responsible for and shall defend, indemnify and hold LESSOR, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the storage, use, and disposal of Toxic Materials on the Premises by COUNTY. If the storage, use, and disposal of Toxic Materials on the Premises by COUNTY results in contamination or

deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, COUNTY shall promptly take any and all action necessary to clean up such contamination.

Likewise, LESSOR hereby warrants and represents that LESSOR has in the past and will hereafter comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "Toxic Materials"). LESSOR shall be responsible for and shall defend, indemnify and hold COUNTY, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the previous, current and future storage, use and disposal of Toxic Materials on the Premises (or building if the Premises comprises only a portion of said building) by LESSOR. If the previous, current and future storage, use, and disposal of Toxic Materials on the Premises by LESSOR results in contamination or deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, LESSOR shall promptly take any and all action necessary to clean up such contamination.

15. SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE (6.4 S)

This Lease and all rights of the COUNTY hereunder are subject and subordinate to any mortgage or deed of trust which does now or may hereafter cover the Premises or any interest of LESSOR therein, and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions of any such mortgage or deed of trust; except, insofar as COUNTY is meeting its obligations under this Lease, any foreclosure of any mortgage or deed of trust shall not result in the termination of this Lease or the displacement of COUNTY.

In the event of transfer of title to the Premises, including any proceedings brought for foreclosure or in the event of the exercise of the power of sale under any mortgage or deed of trust or by any other transfer of title covering the Premises, COUNTY shall attorn to and recognize any subsequent title holder as the LESSOR under all terms, covenants and conditions of this Lease. COUNTY's possession of the Premises shall not be disturbed by the LESSOR or its successors in interest, and this Lease shall remain in full force and effect. Said attornment shall be effective and self-operative immediately upon succession of the current title holder, or its successors in interest, to the interest of LESSOR under this Lease.

Notwithstanding the above, this Lease is contingent upon LESSOR's obtaining a Subordination, Attornment and Non-Disturbance Agreement from LESSOR’s lender, within thirty (30) days of

LESSOR's execution of this Lease. LESSOR shall require all future lenders on the Premises upon initiation of their interest in the Premises, to enter into a Subordination, Attornment and Non-Disturbance Agreement with COUNTY thereby insuring COUNTY of its leasehold interests in the Premises. Said Subordination, Attornment and Non-Disturbance Agreement shall be in the form of COUNTY's standard form Subordination, Attornment and Non-Disturbance Agreement shown on Exhibit E, attached hereto and by reference made a part hereof, or in a form approved by the Chief Real Estate Officer, and County Counsel.

Foreclosure shall not extinguish this Lease, and any lender or any third party purchasing the Premises at foreclosure sale shall do so subject to this Lease and shall thereafter perform all obligations and be responsible for all liabilities of the LESSOR under the terms of this Lease.

Upon default by LESSOR of any note or deed of trust, COUNTY may, at its option, make all lease payments directly to the lender, and same shall be applied to the payment of any and all delinquent or future installments due under such note or deed of trust.

16. ESTOPPEL CERTIFICATE (6.5 S)

COUNTY agrees that the County Executive Officer shall furnish from time to time upon receipt of a written request from LESSOR or the holder of any deed of trust or mortgage covering the Premises or any interest of LESSOR therein, COUNTY's standard form Estoppel Certificate containing information as to the current status of the Lease. The Estoppel Certificate shall be approved by the Chief Real Estate Officer, and County Counsel.

17. DEFAULTS AND REMEDIES (6.8 S)

The occurrence of any of the following shall constitute an event of default:

- Failure to pay any installment of any monetary amount due and payable hereunder;
- Failure to perform any obligation, agreement or covenant under this Lease.

In the event of any non-monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to initiate action to cure said breach.

In the event of any non-monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach and LESSOR shall have fifteen (15) days in which to initiate action to cure said

breach.

In the event of any monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

In the event of any monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach, and LESSOR shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

18. DEBT LIMIT (6.9 S)

LESSOR acknowledges and agrees that the obligation of the COUNTY to pay rent under this Lease is contingent upon the availability of COUNTY funds which are appropriated or allocated by the COUNTY's Board of Supervisors for the payment of rent hereunder. In this regard, in the event that this Lease is terminated due to an uncured default of the COUNTY hereunder, LESSOR may declare all rent payments to the end of COUNTY's current fiscal year to be due, including any delinquent rent from prior budget years. In no event shall LESSOR be entitled to a remedy of acceleration of the total rent payments due over the term of the Lease. The Parties acknowledge and agree that the limitations set forth above are required by Article 16, section 18, of the California Constitution. LESSOR acknowledges and agrees that said Article 16, section 18, of the California Constitution supersedes any law, rule, regulation or statute, which conflicts with the provisions of this paragraph. Notwithstanding the foregoing, LESSOR may have other rights or civil remedies to seek relief due to the COUNTY's default under the Lease. Such rights or remedies may include a right to continue the COUNTY's right of possession under the Lease and sue for the rent as it becomes past due.

19. LABOR CODE COMPLIANCE (6.10 S)

LESSOR acknowledges and agrees that all improvements or modifications required to be performed as a condition precedent to the commencement of the term of this Lease or any such future improvements or modifications performed by LESSOR at the request of COUNTY shall be governed by, and performed in accordance with, the provisions of Article 2 of Chapter 1, Part 7, Division 2 of the Labor Code of the State of California (Sections 1770, et seq.). These provisions are applicable to improvements or modifications costing more than $1,000.

Pursuant to the provisions of Section 1773 of the Labor Code of the State of California, the Orange County Board of Supervisors has obtained the general prevailing rate of per diem wages and the general prevailing

rate for holiday and overtime work in the locality applicable to this Lease for each craft, classification, or type of workman needed to execute the aforesaid improvements or modifications from the Director of the State Department of Industrial Relations. Copies of said prevailing wage rates may be obtained from the State of California, Department of Industrial Relations, or the County Executive Officer.

LESSOR hereby agrees to pay or cause its contractors and/or subcontractors to pay said prevailing wage rates at all times for all improvements or modifications to be completed for COUNTY within the premises, and LESSOR herein agrees that LESSOR shall post, or cause to be posted, a copy of the most current, applicable prevailing wage rates at the site where the improvements or modifications are performed.

Prior to commencement of any improvements or modifications, LESSOR shall provide the County Executive Officer with the applicable certified payroll records for all workers that will be assigned to the improvements or modifications. Said payroll records shall contain, but not be limited to, the complete name, address, telephone number, social security number, job classification, and prevailing wage rate for each worker. LESSOR shall provide, the County Executive Officer bi-weekly updated, certified payroll records for all workers that include, but not be limited to, the weekly hours worked, prevailing hourly wage rates, and total wages paid.

If LESSOR neglects, fails, or refuses to provide said payroll records to the County Executive Officer, such occurrence shall constitute an event of default of this lease and COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY's sole option, COUNTY may deduct future rent payable to LESSOR by COUNTY as a penalty for such non-compliance of paying prevailing wage, which rent deduction would be COUNTY's estimate, in its sole discretion, or such prevailing wage rates not paid by LESSOR.

Except as expressly set forth in this Lease, nothing herein is intended to grant authority for LESSOR to perform improvements or modifications on space currently leased by COUNTY or for which COUNTY has entered into a lease or lease amendment.

20. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (6.12 S)

In order to comply with child support enforcement requirements of the County of Orange, within thirty (30) days after COUNTY's execution of this Lease agreement, LESSOR agrees to furnish the County Executive Officer, COUNTY's standard form, *Child Support Enforcement Certification Requirements*, which includes the following information:

A. In the case where LESSOR is doing business as an individual, LESSOR's name, date of birth, Social Security number, and residence address;

B. In the case where LESSOR is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;

C. A certification that the LESSOR has fully complied with all applicable federal and state reporting requirements regarding its employees; and

D. A certification that the LESSOR has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, and will continue to so comply.

Failure of LESSOR to timely submit the data and/or certifications required above or to comply with all federal and state reporting requirements for child support enforcement, or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, shall constitute a material breach of this Lease. Failure to cure such breach within sixty (60) calendar days of notice from the County Executive Officer shall constitute grounds for termination of this Lease.

Notwithstanding any other provisions of this Lease, LESSOR shall be given an opportunity to cure as follows:

A. A notice of any claimed failure to comply shall be given to LESSOR, in writing, by personal delivery, or facsimile transmission, from the County Executive Officer. The written notice shall state the specific data or certification required, the specific federal or state reporting requirements for child support enforcement that has not been complied with or the specific Wage and Earnings Assignment Order and Notice of Assignment that has not been complied with; and

B. LESSOR shall have sixty (60) days from the actual receipt of the written notice to cure the failure to comply specified in the notice, provided that LESSOR's performance to cure within sixty (60) days is not hindered, impaired or prevented by federal, state or local agencies. If the claimed failure as set forth in the written notice is failure to perform an act by a certain time, the failure of performance of said certain act by said certain time shall be deemed cured for purposes of this Lease if it is timely performed in accordance with the provisions of this paragraph.

It is expressly understood that this data will be transmitted to governmental agencies charged with the

establishment and enforcement of child support orders and will not be used for any other purpose.

21. RIGHT TO WORK AND MINIMUM WAGE LAWS (6.13 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LESSOR shall require its employees that directly or indirectly service the Premises or terms and conditions of this Lease, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LESSOR shall also require and verify that its contractors or any other persons servicing the Premises or terms and conditions of this Lease, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LESSOR shall pay no less than the greater of the Federal or California minimum wage to all its employees that directly or indirectly service the Premises, in any manner whatsoever. LESSOR shall require and verify that all its contractors or other persons servicing the Premises on behalf of the LESSOR also pay their employees no less than the greater of the Federal or California minimum wage.

LESSOR shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the Premises or terms and conditions of this Lease.

Notwithstanding the minimum wage requirements provided for in this clause, LESSOR, where applicable, shall comply with the prevailing wage and related requirements, as provided for in the Clause entitled LABOR CODE COMPLIANCE of this Lease.

22. AUTHORITY (N)

The Parties to this Lease represent and warrant that this Lease has been duly authorized and executed and constitutes the legally binding obligation of their respective organization or entity, enforceable in accordance with its terms.

23. NOTICES (8.1 S)

All written notices pursuant to this Lease shall be addressed as set forth below or as either party may hereafter designate by written notice and shall be deemed delivered upon personal delivery, delivery by facsimile machine, or seventy-two (72) hours after deposit in the United States Mail.

TO: LESSOR Charles H. Manh and Anh Manh Manh Family Trust 8990 Westminster Blvd., Second Floor Westminster, CA 92683	TO: COUNTY County of Orange 333 Santa Ana Blvd., 3rd Floor Santa Ana, CA 92701 Attention: Scott Mayer, Chief Real Estate Officer Email: Scott.Mayer@ocgov.com Phone: (714) 834-3046

24. ATTACHMENTS (8.2 S)

This Lease includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
   A. Description - Premises
   B. Plot Plan - Premises
   C. Performance Specifications
   D. Janitorial Specifications
   E. Subordination, Attornment, and Non-Disturbance Agreement

25. MISCELLANEOUS (N)

COUNTY may remove and dispose, and in a manner best suited for such removal and disposition, of any item(s) of furniture ("**Furniture Items**") off the Premises, which is (are) personal property of the LESSOR, as COUNTY deems appropriate or is of no use for COUNTY. LESSOR hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of property arising from, growing out of or in any way connected with or related to the removal and disposition of the Furniture Items except claims arising from the concurrent active negligence of COUNTY, its officers, agents, and employees.

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IN WITNESS WHEREOF, the parties have executed this Agreement the day and year first above written.

LESSOR

CHARLES H. MANH and ANH MANH,
Co-Trustees of the MANH FAMILY TRUST, dated August 15, 2006

By: _____ May 25th, 2016
CHARLES H. MANH, Co-Trustee

By: _____ May 25th, 2016
ANH MANH, Co-Trustee

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APPROVED AS TO FORM:

OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By _____
Deputy County Counsel

COUNTY

COUNTY OF ORANGE
Chief Real Estate Officer

_____
By: Scott D. Mayer Per Ordinance No. 15-009 of the Board of Supervisors and Minute Order dated June 9, 2015

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GENERAL CONDITIONS (9.1-9.17 S)

1. LEASE ORGANIZATION (9.1 S)

The various headings in this Lease, the numbers thereof, and the organization of the Lease into separate sections and paragraphs are for purposes of convenience only and shall not be considered otherwise.

2. INSPECTION (9.2 N)

LESSOR or his authorized representative shall have the right at all reasonable times and upon reasonable advance notice to COUNTY, which authorization shall not be unreasonably withheld, to inspect the Premises to determine, if COUNTY is complying with all the provisions of this Lease.

3. SUCCESSORS IN INTEREST (9.3 S)

Unless otherwise provided in this Lease, the terms, covenants, and conditions contained herein shall apply to and bind the heirs, successors, executors, administrators, and assigns of all the parties hereto, all of whom shall be jointly and severally liable hereunder.

4. DESTRUCTION OF OR DAMAGE TO PREMISES (9.4 S)

"Partial Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is less than 25% of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

"Total Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is 25% or more of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

In the event of a Partial Destruction of the Premises, LESSOR shall immediately pursue completion of all repairs necessary to restore the Premises to the condition which existed immediately prior to said Partial Destruction. Said restoration work (including any demolition required) shall be completed by LESSOR, at LESSOR's sole cost, within sixty (60) days of the occurrence of said Partial Destruction or within an extended time frame as may be authorized, in writing, by COUNTY. The Partial Destruction of the Premises shall in no way render this Lease and/or any option to purchase null and void; however, rent payable by COUNTY under the Lease shall be abated in proportion to the extent COUNTY's use and occupancy of the Premises is adversely affected by said Partial Destruction, demolition, or repair work

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required thereby. Should LESSOR fail to complete necessary repairs, for any reason, within sixty (60) days, or other time frame as may be authorized by COUNTY, COUNTY may, at COUNTY's sole option, terminate the Lease or complete necessary repair work and deduct the cost thereof, including labor, materials, and overhead from any rent thereafter payable.

In the event of Total Destruction of the Premises or the Premises being legally declared unsafe or unfit for occupancy, this Lease and/or any option shall in no way be rendered null and void and LESSOR shall immediately instigate action to rebuild or make repairs, as necessary, to restore the Premises (including replacement of all tenant improvements) to the condition which existed immediately prior to the destruction. All rent payable by COUNTY shall be abated until complete restoration of the Premises is accepted by COUNTY. In the event LESSOR refuses to diligently pursue or is unable to restore the Premises to an occupiable condition (including replacement of all tenant improvements) within 180 days of the occurrence of said destruction or within an extended time frame as may be authorized, in writing, by COUNTY, COUNTY may, at COUNTY's sole option, terminate this Lease or complete the restoration and deduct the entire cost thereof, including labor, materials, and overhead from any rent payable thereafter.

Further, LESSOR, at COUNTY's request, shall provide a suitable, COUNTY-approved temporary facility ("**Facility**") for COUNTY's use during the restoration period for the Premises. The Facility may be leased, at market rate, under a short term lease, for which the COUNTY will reimburse LESSOR the cost thereof, on a monthly basis.

5. AMENDMENT (9.5 S)

This Lease sets forth the entire agreement between LESSOR and COUNTY and any modification must be in the form of a written amendment.

6. PARTIAL INVALIDITY (9.6 S)

If any term, covenant, condition, or provision of this Lease is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

7. CIRCUMSTANCES WHICH EXCUSE PERFORMANCE (9.7 S)

If either Party hereto shall be delayed or prevented from the performance of any act required hereunder by reason of acts of God, performance of such act shall be excused for the period of the delay; and the period for the performance of any such act shall be extended for a period equivalent to the period of such

delay. Financial inability shall not be considered a circumstance excusing performance under this Lease.

8. WAIVER OF RIGHTS (9.9 S)

The failure of LESSOR or COUNTY to insist upon strict performance of any of the terms, conditions, and covenants in this Lease shall not be deemed a waiver of any right or remedy that LESSOR or COUNTY may have, and shall not be deemed a waiver of any right or remedy for a subsequent breach or default of the terms, conditions, and covenants herein contained.

9. HOLDING OVER (9.10 S)

In the event COUNTY shall continue in possession of the Premises after the term of this Lease, such possession shall not be considered a renewal of this Lease but a tenancy from month to month and shall be governed by the conditions and covenants contained in this Lease.

10. HAZARDOUS MATERIALS (9.11 S)

LESSOR warrants that the Premises is free and clear of all hazardous materials or substances.

11. EARTHQUAKE SAFETY (9.12 N)

LESSOR is informed and believes that the Premises is not in violation of any applicable seismic safety regulations and building codes.

12. QUIET ENJOYMENT (9.13 S)

LESSOR agrees that, subject to the terms, covenants and conditions of this Lease, COUNTY may, upon observing and complying with all terms, covenants and conditions of this Lease, peaceably and quietly occupy the Premises.

13. WAIVER OF JURY TRIAL (9.15 S)

Each Party acknowledges that it is aware of and has had the advice of Counsel of its choice with respect to its rights to trial by jury, and each party, for itself and its successors and assigns, does hereby expressly and knowingly waive and release all such rights to trial by jury in any action, proceeding or counterclaim brought by any party hereto against the other (and/or against its officers, directors, employees, agents, or subsidiary or affiliated entities) on or with regard to any matters whatsoever arising out of or in any way

connected with this agreement and/or any claim of injury or damage.

14. GOVERNING LAW AND VENUE. (9.16 S)

This agreement has been negotiated and executed in the State of California and shall be governed by and construed under the laws of the State of California. In the event of any legal action to enforce or interpret this agreement, the sole and exclusive venue shall be a court of competent jurisdiction located in Orange County, California, and the parties hereto agree to and do hereby submit to the jurisdiction of such court, notwithstanding Code of Civil Procedure section 394.

15. TIME (9.17 S)

Time is of the essence of this Lease.

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EXHIBIT A

DESCRIPTION OF PREMISES (10.1 N)

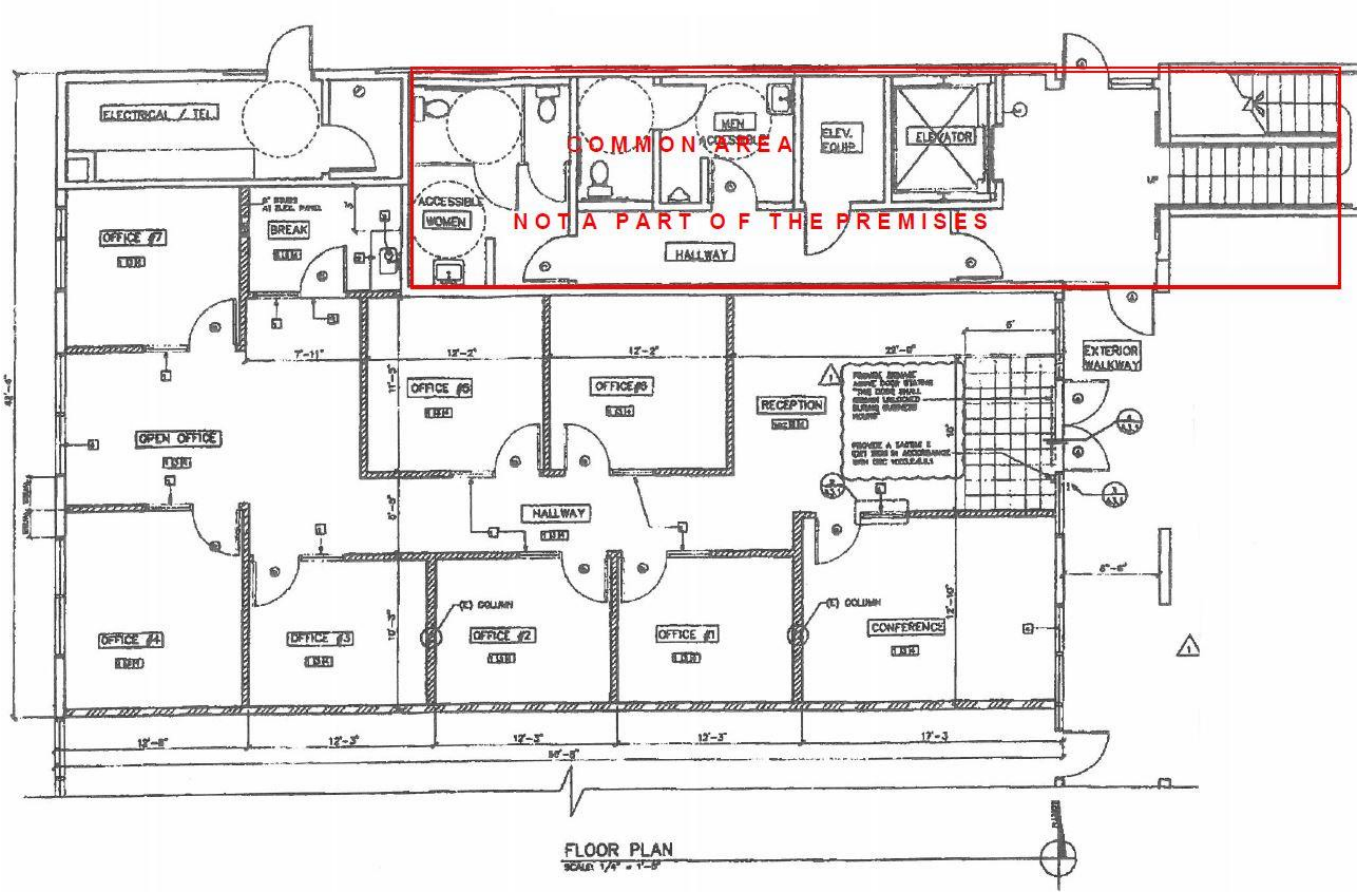
PROJECT: Community Customer Service Annex

All the Premises shown as the floor plan marked Exhibit B, attached hereto and made a part hereof, being a portion of the first floor of that certain two (2) story building located at 15496 Magnolia Street, Suite 111, in the City of Westminster, County of Orange, State of California, together with non-exclusive use of common area restrooms and thirteen (13) parking spaces in the parking areas shown on Exhibit B.

NOT TO BE RECORDED

EXHIBIT B
FLOOR PLAN OF PREMISES

15496 MAGNOLIA STREET, SUITE 111,
WESTMINSTER, CA



Gross Leasable Area: 2,120 Square Feet

EXHIBIT C

PERFORMANCE SPECIFICATIONS (10.3N) LESSOR shall perform the following Work prior to the Commencement Date of this Lease and according to the Tenant Improvement Performance Specifications that follow:

Specific locations to be identified by COUNTY prior to lease execution

1. Repair or replace door closer.
2. Replace stained ceiling tiles.
3. Repair or replace door closer.
4. Remove any signage from previous tenant that exists inside or outside of the Premises
5. Re-key front door and any internal door locks.
6. Provide the security code for existing alarm system.
7. Deliver the Premises with all electrical, plumbing and HVAC systems in proper working order.
8. Repair or replace any HVAC components resulting from findings of COUNTY's inspection of the HVAC system.

1. HEAT, VENT & AIR CONDITION ("HVAC")

A. Heating & air conditioning equipment shall have the capability of maintaining all occupied indoor areas at the room temperatures shown when outdoor temperatures are as follows:

OUTDOORS	*MAINTAIN INDOORS*
Summer – 95° Dry Bulb	78° Dry Bulb at a maximum range of 40% to 60% Relative humidity
Winter – 35° Dry Bulb	68° Dry Bulb

B. All HVAC controls pertinent to the Premises are to be located within the Premises.

C. All HVAC thermostats shall be concealed by a clear plastic tamper proof lock box.

2. ELECTRICAL & COMMUNICATIONS

A. Provide and install fluorescent lighting at all interior spaces that meet code and provide the following minimum lighting intensities at desk level:

LOCATION	*MINIMUM FOOT CANDLES:*
General Offices/Utility Rooms	60
Public Areas	30
General Corridors	20
LOCATION	*MINIMUM FOOT CANDLES:*
Other interior areas	I.E.S. Recommended Levels
Parking Lot	1

B. All Lighting controls pertinent to the Premises shall be located within the Premises.

COMPLIANCE WITH AMERICANS WITH DISABILITIES ACT ("ADA")

LESSOR shall assure that the Premises and Property are in compliance with current standards of the Americans with Disabilities Act for ingress and egress to the Premises and Property.

EXHIBIT D

JANITORIALSPECIFICATIONS (10.4 N)

It is the intent of this Exhibit to provide general guidelines for minimum janitorial service. Any absence of a specific janitorial service from this Exhibit does not relieve LESSOR of the obligation to provide such service should it become necessary.

Janitorial service as required in the clause entitled (REPAIR, MAINTENANCE AND JANITORIAL SERVICE) of this Lease, shall be inclusive of, but not limited to, the services as detailed below:

RESTROOMS

A. **NIGHTLY**:

1. Clean and damp-mop floors;
2. Wash all mirrors, bright work and enameled surfaces;
3. Wash and sanitize all basins, bowls, urinals, and toilet seats;
4. Dust, clean, and wash where necessary, all partitions, tile walls, dispensers, and receptacles;
5. Empty and sanitize all receptacles and sanitary napkin disposals;
6. Provide materials and fill all toilet tissue, towel, seat cover, sanitary napkin, and soap dispensers.

B. **MONTHLY**:

1. Machine strip restroom floors and apply finish/sealer where applicable;
2. Wash all partitions, tile walls, and enamel surfaces;
3. Vacuum all louvers, vents, and dust light fixtures.

MISCELLANEOUS SERVICES

1. Maintain building common/shared areas, corridors, and other public areas in a clean condition;
2. Surface parking lot is to be cleaned on a monthly or more frequent basis;
3. All interior and exterior windows of the building are to be cleaned quarterly.

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EXHIBIT E

SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT

THIS IS A SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT, made _____, 20__, by and between the County of Orange ("COUNTY") and _____ ("LENDER").

A. By lease dated _____, ("Lease"), _____ ("LESSOR") leased to COUNTY and COUNTY leased from LESSOR those certain Premises described as: _____.

B. LENDER is the holder or about to become the holder of a mortgage or Deed of Trust ("Note") which constitutes or will constitute a lien against the Premises leased by COUNTY pursuant to the aforesaid Lease.

C. LENDER has requested that _____ execute a Subordination, Attornment and Non-Disturbance Agreement in accordance with the terms of the Lease.

NOW, THEREFORE, the parties hereto do hereby agree as follows:

1. Subject to the terms and conditions of the Lease, all rights of COUNTY thereunder are or shall become subordinate to the Note and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions thereof.

2. In the event that LENDER succeeds to the interest of LESSOR under the Lease, by reason of foreclosure of the Note, by other proceedings brought to enforce any rights of LENDER under the Note, by deed in lieu of foreclosure, or by any other method, COUNTY shall promptly attorn to LENDER under all of the terms, covenants, and conditions of the Lease for the balance of the then-current term (and any extension or renewals thereof which may be effective in accordance with any option therefore contained in the Lease), with the same force and effect as if LENDER were the Lessor under the Lease. So long as COUNTY is not in default under the Lease, LENDER or its successors in interest shall not disturb the interests of COUNTY under said Lease, but shall allow said interests to continue in full force and effect for the balance of the then-current term and any extension available to COUNTY which may be provided in accordance with the Lease. Said attornment shall be effective and self-operative immediately upon LENDER'S succession to the interest of LESSOR under the Lease.

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3. This agreement may not be modified orally or in any manner other than by written agreement signed by the parties hereto or their respective successors or assigns. All of the terms, covenants, and conditions herein shall run with the land and shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

COUNTY:

COUNTY OF ORANGE

By:_____

County Chief Real Estate Officer

LENDER:

By:_____

Print Name:_____

Title:_____

APPROVAL AS TO FORM:
OFFICE OF THE COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By:_____

Deputy County Counsel

Date:_____

H.L. MILLER incorporated

A General Construction Company

PROPOSAL

Date	Proposal #
7/27/2016	3827

Name / Address
SOCIAL SERVICES AGENCY 500 N. State College Blvd. Orange, CA 92868 ATTN: AL PASILLAS E: Al.Pasillas@ssa.ocgov.com

Description	Total
JOB SITE: 15946 Magnolia, Suite 111 - Wall Removal REF: MA-063-16011114	
1. Remove 18' x 9' of wall with one window and one door and haul away. 2. Finish corner and replace any ceiling tiles damaged from the wall removal. Remove switches in conference room and tie lighting in both rooms to one set of switches. CARPENTER: 17 Hours at $85/Hr = $1,445.00 DRYWALL: 6 Hours at $90/Hr = $540.00 PAINTING: 4 Hours at $80/Hr = $320.00 ELECTRICAL: 9 Hours at $75/Hr = $675.00 ELECTRICAL HELPER: 9 Hours at $50/Hr = $450.00 ESTIMATED MATERIAL: $350.00 + 10% = $385.00	3,815.00
3. Remove carpet in both rooms and haul away. Prep floor and install 65.5 Sq. Yds. of level loop light to medium beige carpet. FLOORING: 18 Hours at $61/Hr - $1,098.00 ESTIMATED MATERIAL: $1,902.41 + 10% = $2,091.55	3,189.55
4. Repair carpet with similar color where wall was removed. (4" x 15'). FLOORING: 6 Hours at $61/Hr = $366.00 ESTIMATED MATERIAL: $250.00 + 10% = $275.00	641.00
Howard L. Miller, President JA QUOTE IS GOOD FOR 60 DAYS.	

Please make checks payable to:H.L. Miller, Inc. CA State Contractors Lic. #385912 Tax ID 56-2399764	**Total** $7,645.55

PURSUANT TO CALIFORNIA PUBLIC CONTRACT CODE, SECTION 20104.50, INTEREST IS DUE IF NOT PAID WITHIN 30 DAYS OF THE ABOVE DATE, AT THE RATE ALLOWED IN THE CODE OF CIVIL PROCEDURE SECTION 685.101.

2201 E. Winston Road, Unit I, Anaheim, CA 92806-5537
Phone: (714) 998-8699 • Fax: (714) 998-8698 • Email: hlmcinc@aol.com

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

34. Consider Authorizing Extension of License Agreement with the County of Orange for Use of Space at the County Community Service Center

Contact

Phil Tsunoda, Executive Director Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to negotiate an Amendment to the License Agreement compliant with CalOptima's obligations under applicable state and federal laws regarding the privacy of CalOptima members and their protected health information and extend the License Agreement with the County of Orange for up to an additional four years through June 30, 2021, which allows use of approximately 362 square feet of space at the County Community Service Center (CCSC), located at 15496 Magnolia Street, Suite 111, Westminster, CA 92683;
2. Approve allocation of $18,831.76, which has been included in CalOptima's proposed Fiscal Year (FY) 2017-2018 Operating Budget to fund the extension of the License Agreement; and .
3. Authorize staff expenditures of $66,230 in FY 2017-18, plus equipment for a full time Customer Service Representative (CSR) at the licensed site.

Background

As a public agency and community health plan that serves the low-income Medi-Cal population in Orange County, CalOptima has been committed to member outreach, health education and engagement since its inception. By actively engaging our members in efforts with our community-based organizations, we increase opportunities for our members to receive information regarding our programs, learn about their benefits and be more proactive participants in their own health care.

Since 2008, CalOptima utilized space at the main CCSC office at no cost to CalOptima to offer monthly education seminars to increase our members' knowledge about CalOptima's programs and services and information to support our members' health care needs. Due to CalOptima's growth in membership and programs and increased interest in the health education seminars, the space at the main office limited the number of members served at the main CCSC office.

In May 2016, Orange County Social Services Agency informed CalOptima of an opportunity to expand our capacity at the CCSC by licensing space located across the parking lot from the main CCSC office. The licensed space provides one dedicated office and access to a shared conference room 50 percent of the time. On August 4, 2016, CalOptima's Board of Directors authorized the CEO to enter into a one-year license agreement with the County of Orange for usage of the space at the CCSC at a cost of approximately $23,000 for removal of a wall and licensing fees through June 30, 2017.

Since September 2016, CalOptima staff has been on-site to provide information and education about CalOptima's programs and services, enhanced customer service support, and additional monthly

educational seminars. The satellite office is centrally-located in the county and may be more convenient for certain CalOptima members who reside in the cities of Santa Ana, Garden Grove and Westminster. While visitation has been limited to an average of less than two members per day to date, staff is hopeful that a greater number of members will be receiving information at the site in the future.

Since the CCSC grand opening in September 2016, staff from various CalOptima departments have been on-site to serve members including Behavioral Health Integration, Program of All-Inclusive Care (PACE), OneCare Connect Sales and Marketing, Customer Service and Community Relations Departments. Services offered on-site include information and referrals for our programs and services, information and enrollment in the PACE and OneCare Connect programs, assistance with navigating health care benefits, educational seminars and customer service related issues including provider and health network selection, referrals, and requesting replacementID cards.

Since the opening of the new CCSC site, CalOptima has increased the health education seminars from one Vietnamese health education seminar to three seminars per month to include English and Spanish seminars, expanding our reach to English and Spanish-speaking members. CalOptima collaborated with community-based organization and internal departments to provide 21 educational seminars over the past nine months, or roughly three events per month, at the CCSC site. Topics presented include:

- The Importance of Vaccinations
- Understanding Social Security Programs and Benefits
- Dementia: The Basics: What it is and is not?
- Who is CalOptima? Understanding Your Medi-Cal Benefits
- Good Oral Care: Understanding Your Denti-Cal Benefits and Accessing Dental Services
- Mental Health Wellness: Understanding and Accessing Behavioral Health Benefits and Services

In January 2017, CalOptima started offering New Member Orientations for our Vietnamese-speaking members at the satellite office. A total of six New Member Orientations were conducted for our Medicare/Medi-Cal members and new Medi-Cal members.

Over 350 members have been provided with information and health education at the licensed site through the activities listed above in the nine months since the site's opening in September 2016. Foot traffic has averaged one to two members daily, and staff is hopeful that more members will receive information from the location with increased awareness of the licensed site and additional outreach efforts to members, providers and community-based organizations.

In addition to CalOptima's services, the CCSC offers a variety of health and human services to local residents including resources and referrals, application assistance and education workshops to assist with housing, mental and public health and support services for older adults. Representatives from Health Care Agency, Housing Authority, Family Caregiver Resource Center, and Office on Aging and Council on Aging are available to assist members on designated days.

CalOptima's primary challenge at the licensed site has been the lack of full-time staff available to serve our members on-site. While staff has made many efforts to provide full-time coverage by developing shifts for various departments, we still received feedback from members about the importance of having a full-time Customer Service Representative on-site. Staff has addressed this concern by budgeting for an additional full-time, bi-lingual Customer Service Representative who will begin duties at the CCSC in late May 2017.

To increase awareness of the licensed site in the community, CalOptima is implementing a number of outreach strategies to members, internal departments, health networks, providers and community-based organizations to increase utilization of services available. Activities include mailers to members residing in a two-mile radius of the satellite office, communications to health networks and providers through CalOptima's newsletters and weekly communications, and targeted site visits to providers, health clinics and community-based organizations within a two-mile radius.

Discussion

Staff recommends authorization to negotiate an amendment to the License Agreement to ensure compliance with applicable state and federal privacy laws and to extend the License Agreement with the County of Orange. The licensed site establishes a presence in the community and is available to provide information to members regarding benefits and health education to support their health care needs.

The current License Agreement allows for one dedicated office, shared use of a conference room and use of the common area. The total leased space for the CCSC is comprised of 2,080 square feet with CalOptima's use of 109 square feet for the dedicated office, 253 square feet for the shared conference room, and estimated 21 percent use of the common area. The License Agreement was approved by CalOptima's Board of Directors on August 4, 2016 for the license period of August 5, 2016 through June 30, 2017.

The proposed extension of the License Agreement for the CCSC would include an increase in the license term for an additional four years through June 30, 2021, increase in the monthly license fee from $1,453.02 per month to $1,560.98 per month for the months of July 1, 2017 through June 30, 2021, and the addition of a new standard insurance clause requiring CalOptima to meet all County insurance's requirements. CalOptima would also negotiate additional amendments as necessary to ensure compliance with applicable state and federal privacy requirements.

The Director of Financial Compliance reviewed the insurance requirements in the Amendment with CalOptima's broker and confirmed that CalOptima can meet these requirements; as proposed, this location can be added to CalOptima's General Liability policy at an additional annual premium of no more than $100.

	Total Amount
License Fee (July 2017 - June 2018) • Fee includes leased space, IT services, telephone services, janitorial services, and electrical/utilities	$18,731.76
Standard Insurance	$100.00
Computer and telecommunications equipment	$5,000.00
Full time bilingual customer service representative	$66,230.00
Total	$90,061.76

As proposed, the amended License Agreement would take effect on July 1, 2017, contingent on successful negotiations with the County and the agreement being fully executed and approved by the County of Orange's Board of Supervisors. The contract allows CalOptima to cancel the contract with 30-day's notice at any time.

The County of Orange's proposed extension to the License Agreement is for up to four additional years for the period of July 1, 2017 through June 30, 2021. Staff is proposing approval of the License Agreement for this period.

Fiscal Impact
The fiscal impact to execute a license agreement amendment to extend the term of the contract with the County of Orange for the period of July 2, 2017 through June 30, 2021, is approximately $75,000. Of this amount, $18,831.76 is budgeted under the proposed CalOptima FY 2017-18 Operating Budget pending Board approval for the period of July 1, 2017 through June 30, 2018. In addition, the annual cost of placing a full time bilingual customer service representative at the site is projected to total $66,230 in FY2017-18, plus $5,000 for computer/telework equipment for a total of $90,061.76 for FY 2017-18.

Rationale for Recommendation
As part of CalOptima's mission, staff works toward providing access to health care services for our members. By operating a licensed site in central Orange County, CalOptima is able to expand services to our members and build a presence in the community. The satellite office provides CalOptima with an opportunity to expand services to its members and provide direct support, increasing their ability to access health care.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Fully Executed County of Orange License Agreement-Original
2. CCSC Cost Apply

/s/ Michael Schrader — *5/25/2017*
Authorized Signature — **Date**

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GA 1213-237
SSA/CalOptima

LICENSE AGREEMENT

This LICENSE AGREEMENT (**"License"**) is made and entered into August 4, 2016 (**"Effective Date"**), by and between, CALOPTIMA, (hereinafter referred to as **"LICENSEE"**) and COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**) without regard to number and gender. LICENSEE and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**."

RECITALS

I. COUNTY leases that certain real property located at 15496 Magnolia in the City of Westminster, (**"County Property"**) pursuant to a lease dated July 1, 2016 for COUNTY's Social Services Agency's (**"SSA"**) Orange County Community Service Center Annex (**"OCCSCA"**).

II. The Services provided by LICENSEE will include a convenient on-site source while SSA clients are at the SSA Office.

III. COUNTY agrees to provide LICENSEE sufficient office space within the SSA Office for LICENSEE to provide the Services.

NOW THEREFORE, in consideration of the Recitals above, incorporated herein by reference, COUNTY and LICENSEE do hereby agree as follows:

1. DEFINITIONS (AMLC-2.1 S)

The following words in this License have the significance attached to them in this clause, unless otherwise apparent from context:

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"Chief Real Estate Officer" means the Chief Real Estate Officer, County Executive Office, County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"**Facilities Services Manager**" means the Manager of the Social Services Agency, Facilities Services, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Director of Social Services Agency.

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"Risk Manager" means the Manager of County Executive Office, Risk Management, for the County of Orange, or upon written notice to LICENSEE, such entity as shall be designated by the County Executive Officer.

"SSA Director" means the Director of Social Services Agency, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. TERM (AMLC-3.1 N)

The term of this License shall commence on the Effective Date and terminate on June 30, 2017, unless terminated as provided in Clause 3 (TERMINATION) of this License.

3. TERMINATION (AMLC-3.3 S)

This License shall be revocable by either COUNTY's SSA Director or LICENSEE at any time; however, as a courtesy the Parties will attempt to give thirty (30) days written notice to the other Party upon revocation.

4. LICENSE AREA (AMLC-4.2 N)

COUNTY grants to LICENSEE the non-exclusive right to use that certain property hereinafter referred to as **"License Area,"** shown on Exhibit A, attached hereto and by reference made a part hereof, for the purposes set forth in Clause 6 (USE) of this License together with non-exclusive, in common use of COUNTY's elevators, stairways, washrooms, hallways, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to LICENSEE's License Area created by this License.

During the term of this License, the dates and times for use of the License Area will be determined by the Facilities Services Manager, and the location of the License Area is subject to relocation at the sole discretion of the Facilities Operations Manager.

5. PARKING (AMLC-4.4 S)

Throughout the term of this License COUNTY shall provide one (1) parking space for LICENSEE's free and non-exclusive use.

6. USE (AMLC-5.1 N)

LICENSEE's use of the License Area shall be limited to general office to provide clients with health related workshops and information regarding their Medi-Cal benefits.

LICENSEE agrees not to use the License Area for any other purpose nor to engage in or permit any other activity within or from the License Area without prior written permission from the Facilities Services Manager. LICENSEE further agrees not to conduct or permit to be conducted any public or private nuisance in, on, or from the License Area, not to commit or permit to be committed waste on the License Area, and to comply with all governmental laws and regulations in connection with its use of the License Area.

NO ALCOHOLIC BEVERAGES OR TOBACCO PRODUCTS SHALL BE SOLD OR CONSUMED WITHIN THE LICENSE AREA.

7. LICENSE FEE (AMLC-6.1 S)

LICENSEE agrees to pay COUNTY from and after the effective date of this License according to the following schedule:

MONTH	MONTHLY LICENSE FEE
1	$0.00
2	$361.73
3	$1,453.02
4	$1,453.02
5	$1,453.02
6	$1,453.02
7	$1,453.02
8	$1,453.02
9	$1,453.02
10	$1,453.02
11	$1,453.02
12	$1,453.02

The monthly License Fee shall be payable in advance, without prior notice or demand on the first day of each calendar month while this License is in effect without deduction or offset in lawful money of the United States.

In the event the obligation to pay the License Fee begins or terminates on some day other than the first day or last day of the month, the License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month. The fee for any partial calendar month during which this License becomes effective will be payable on such effective date.

8. PAYMENT PROCEDURE (AMLC-7.1 N)

All payments shall be delivered to the County of Orange, Office of the Auditor-Controller, P. O. Box 567 (630 N. Broadway), Santa Ana, California 92702. The designated place of payment may be changed at any time by COUNTY upon ten (10) days written notice to LICENSEE. License Fee payments may be made by check payable to the County of Orange. Said License Fee payment shall include a payment voucher indicating that the payment is for the monthly License Fee for office space at the Orange County Community Service Center Annex in Westminster, California. A duplicate copy of the payment voucher shall be mailed to the County of Orange, Social Services Agency, 500 N. State College Boulevard, Orange, California,

92868, Attention: Facilities Services Manager. LICENSEE assumes all risk of loss if payments are made by mail.

No payment by LICENSEE or receipt by COUNTY of a lesser amount than the payment due shall be deemed to be other than on account of the payment due, nor shall any endorsement or statement on any check or any letter accompanying any check or payment as payment be deemed an accord and satisfaction, and COUNTY shall accept such check or payment without prejudice to COUNTY's right to recover the balance of said payment or pursue any other remedy in this License.

9. CHARGE FOR LATE PAYMENT (AMLC-7.2 S)

LICENSEE hereby acknowledges that late payment of sums due hereunder will cause COUNTY to incur costs not contemplated by this License, the exact amount of which will be extremely difficult to ascertain. Such costs include but are not limited to costs such as administrative processing of delinquent notices, increased accounting costs, etc.

Accordingly, if any payment pursuant to this license is not received by COUNTY by the due date, a late charge of one and one-half percent (1.5%) of the payment due and unpaid plus $100 shall be added to the payment, and the total sum shall become immediately due and payable to the COUNTY. An additional charge of one and one-half percent (1.5%) of said payment, excluding late charges, shall be added for each additional month that said payment remains unpaid.

LICENSEE and COUNTY hereby agree that such late charges represent a fair and reasonable estimate of the costs that COUNTY will incur by reason of LICENSEE's late payment.

Acceptance of such late charges (and/or any portion of the overdue payment) by COUNTY shall in no event constitute a waiver of LICENSEE's default with respect to such overdue payment, or prevent COUNTY from exercising any of the other rights and remedies granted hereunder.

10. UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N)

COUNTY shall be responsible for all charges for all utilities (water, gas and sewer),. County shall be responsible for all maintenance and repairs (including but not limited to: fire alarm, fire extinguisher, HVAC system, elevator maintenance, landscaping, pest control, and trash). COUNTY shall be responsible for telephone service, internet service and janitorial service. All charges for services provided by COUNTY pursuant to this Clause shall be included in LICENSEE's "MONTHLY LICENSE FEE" pursuant to Clause 7. (LICENSE FEE) of the License.

11. CONSTRUCTION AND/OR ALTERATION BY LICENSEE (AMD2.1 S)

COUNTY's Consent. No structures, improvements, or facilities shall be constructed, erected, altered, or made by LICENSEE within the License Area without prior written consent of the Facilities Services Manager. Any conditions relating to the manner, method, design, and construction of said structures, improvements, or facilities fixed by the Facilities Services Manager as a condition to granting such consent, shall be conditions hereof as though originally stated herein. LICENSEE may, at any time and at its sole expense, install and place business fixtures and equipment within License Area.

Strict Compliance with Plans and Specifications. All improvements constructed by LICENSEE within the

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License Area shall be constructed in strict compliance with detailed plans and specifications approved by the Facilities Services Manager.

COUNTY shall contract with a licensed contractor to remove the existing wall between the "Reception Area" and "Room #1" as depicted in Exhibit B, to replace existing carpet, and repair any areas resulting from removing said wall. LICENSEE shall reimburse COUNTY in the amount not to exceed Seven Thousand six hundred forty-five dollars and fifty-five cents ($7,645.55) within twenty (20) business days of COUNTY's submittal to LICENSEE of an invoice from COUNTY.

12. MECHANICS LIENS OR STOP-NOTICES (AMD4.1 S)

LICENSEE shall at all times indemnify, defend with counsel approved in writing by COUNTY and save COUNTY harmless from all claims, losses, demands, damages, cost, expenses, or liability costs for labor or materials in connection with construction, repair, alteration, or installation of structures, improvements, equipment, or facilities within the License Area, and from the cost of defending against such claims, including attorney fees and costs.

In the event a lien or stop-notice is imposed upon the License Area as a result of such construction, repair, alteration, or installation, LICENSEE shall either:

A. Record a valid Release of Lien, or

B. Procure and record a bond in accordance with Section 3143 of the Civil Code, which frees the License Area from the claim of the lien or stop-notice and from any action brought to foreclose the lien.

Should LICENSEE fail to accomplish either of the two optional actions above within fifteen (15) days after the filing of such a lien or stop-notice, the License shall be in default and shall be subject to immediate termination.

13. OWNERSHIP OF IMPROVEMENTS (AMD6.1 N)

All improvements, exclusive of trade fixtures, constructed or placed within the License Area by LICENSEE must, upon completion, be free and clear all liens, claims, or liability for labor or material and at COUNTY's option shall be the property of COUNTY's at the expiration of this License or upon earlier termination hereof. COUNTY retains the right to require LICENSEE, at LICENSEE's cost, to remove all LICENSEE's improvements located on the License Area at the expiration or termination hereof.

14. INSURANCE (AML10.1 N)

LICENSEE agrees to purchase all required insurance at LICENSEE's expense and to deposit with COUNTY certificates of insurance, including all endorsements required herein, necessary to satisfy COUNTY that the insurance provisions of this License have been complied with and to keep such insurance coverage and the certificates and endorsements therefore on deposit with COUNTY during the entire term of this License. This License shall automatically terminate at the same time LICENSEE's insurance coverage is terminated. If within ten (10) business days after termination under this Clause LICENSEE obtains and provides evidence of the required insurance coverage acceptable to Facilities Services Manager, this License may be reinstated at the sole discretion of Facilities Services Manager.

LICENSEE agrees that LICENSEE shall not operate on the License Area at any time the required insurance is not in full force and effect as evidenced by a certificate of insurance and necessary endorsements or, in the interim, an official binder being in the possession of Facilities Services Manager. In no cases shall assurances by LICENSEE, its employees, agents, including any insurance agent, be construed as adequate evidence of insurance. Facilities Services Manager will only accept valid certificates of insurance and

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endorsements, or in the interim, an insurance binder as adequate evidence of insurance. LICENSEE also agrees that upon cancellation, termination, or expiration of LICENSEE's insurance, COUNTY may take whatever steps are necessary to interrupt any operation from or on the License Area until such time as the Facilities Services Manager reinstates the License.

If LICENSEE fails to provide Facilities Services Manager with a valid certificate of insurance and endorsements, or binder at any time during the term of the License, COUNTY and LICENSEE agree that this shall constitute a material breach of the License. Whether or not a notice of default has or has not been sent to LICENSEE, said material breach shall permit COUNTY to take whatever steps necessary to interrupt any operation from or on the License Area, and to prevent any persons, including, but not limited to, members of the general public, and LICENSEE's employees and agents, from entering the License Area until such time as Facilities Services Manager is provided with adequate evidence of insurance required herein. LICENSEE further agrees to hold COUNTY harmless for any damages resulting from such interruption of business and possession, including, but not limited to, damages resulting from any loss of income or business resulting from the COUNTY's action.

All contractors performing work on behalf of LICENSEE pursuant to this License shall obtain insurance subject to the same terms and conditions as set forth herein for LICENSEE. LICENSEE shall not allow contractors or subcontractors to work if contractors have less than the level of coverage required by COUNTY from LICENSEE under this License. It is the obligation of LICENSEE to provide written notice of the insurance requirements to every contractor and to receive proof of insurance prior to allowing any contractor to begin work within the License Area. Such proof of insurance must be maintained by LICENSEE through the entirety of this License and be available for inspection by a COUNTY representative at any reasonable time.
All self-insured retentions (**"SIRs"**) and deductibles shall be clearly stated on the Certificate of Insurance. If no SIRs or deductibles apply, indicate this on the Certificate of Insurance with a "0" by the appropriate line of coverage. Any **SIR** or deductible in excess of $25,000 ($5,000 for automobile liability), shall specifically be approved by COUNTY's Risk Manager.

If LICENSEE fails to maintain insurance acceptable to COUNTY for the full term of this License, COUNTY may terminate this License.

Qualified Insurer

The policy or policies of insurance must be issued by an insurer licensed to do business in the state of California (California Admitted Carrier) or have a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category) as determined by the most current edition of the **Best's key Rating Guide/Property-Casualty/United States or ambest.com**.

If the insurance carrier is not an admitted carrier in the state of California and does not have an A.M. Best rating of A-/VIII, COUNTY's Risk Manager retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by LICENSEE shall provide the minimum limits and coverage as set forth below:

Coverages	Minimum Limits

Coverages	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence $2,000,000 aggregate
Automobile Liability including coverage for owned, non-owned and hired vehicles	$1,000,000 limit per occurrence
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (**"ISO"**) form CG 00 01, or a substitute form providing liability coverage at least as broad.
The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing liability coverage as broad.

Required Endorsements

The following endorsements must be submitted with the Certificate of Insurance:

a) The Commercial General Liability policy shall contain an Additional Insured endorsement using ISO form CG 2010 or CG 2033 or a form at least as broad naming the COUNTY, its elected and appointed officials, officers, employees, and agents as Additional Insureds.

b) The Commercial General Liability policy shall contain a primary non-contributing endorsement evidencing that the LESSEE's insurance is primary and any insurance or self-insurance maintained by the COUNTY shall be excess and non-contributing.

c) The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the COUNTY, and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees.

d) The Commercial Property policy shall contain a Loss Payee endorsement naming the COUNTY as respects the COUNTY's financial interest when applicable.

All insurance policies required by this contract shall waive all rights of subrogation against the COUNTY and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

All insurance policies required by this contract shall give COUNTY thirty (30) days notice in the event of cancellation and ten (10) days for non-payment of premium. This shall be evidenced by policy provisions or an endorsement separate from the Certificate of Insurance.

The Commercial General Liability policy shall contain a severability of interests' clause, also known as a "separation of insureds" clause (standard in the ISO CG 001 policy).

Insurance certificates should be forwarded to COUNTY's address provided in Clause 17 (NOTICES) below or to an address provided by SSA/Facilities Services Manager. LICENSEE has ten (10) business days to provide adequate evidence of insurance or this License may be cancelled.

COUNTY expressly retains the right to require LICENSEE to increase or decrease insurance of any of the above insurance types throughout the term of this License. Any increase or decrease in insurance will be as deemed by COUNTY's Risk Manager as appropriate to adequately protect COUNTY.

COUNTY shall notify LICENSEE in writing of changes in the insurance requirements. If LICENSEE does not deposit copies of acceptable certificates of insurance and endorsements with COUNTY incorporating such changes within thirty (30) days of receipt of such notice, this License may be in breach without further notice to LICENSEE, and COUNTY shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit LICENSEE's liability hereunder nor to fulfill the indemnification provisions and requirements of this License, nor in any way to reduce the policy coverage and limits available from the insurer.

15. OPERATIONS (AMLC-11.1 N)

LICENSEE shall keep and maintain the License Area and all improvements of any kind in good condition and in substantial repair. COUNTY will, on LICENSEE's behalf, provide all maintenance and repairs to the License Area during the term of the License. LICENSEE is required to notify COUNTY of any and all necessary maintenance and repairs to the License Area on a timely basis.

LICENSEE expressly agrees to maintain the License Area in a safe, clean, wholesome, and sanitary condition, to the complete satisfaction of COUNTY and in compliance with all applicable laws. LICENSEE further agrees to keep the License Area free and clear of rubbish and litter. COUNTY shall have the right to enter upon and inspect the License Area at any time for cleanliness and safety.

LICENSEE shall designate in writing to COUNTY an on-site representative who shall be responsible for the day to day operation and level of maintenance, cleanliness, and general order.

16. LIMITATION OF THE LICENSE (AMLC-13.1 S)

This License and the rights and privileges granted LICENSEE in and to the License Area are subject to all covenants, conditions, restrictions, and exceptions of record or apparent from a physical inspection of the License Area. Nothing contained in this License or in any document related hereto shall be construed to imply the conveyance to LICENSEE of rights in the License Area, which exceed those owned by COUNTY.

17. HIPAA NOTICE (N)

LICENSEE acknowledges that the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) requires COUNTY to safeguard and maintain the confidentiality of any Protected Health Information (PHI). LICENSEE hereby agrees not to access, remove, destroy, or relocate any property used by COUNTY to safeguard and store PHI. LICENSEE further agrees to use appropriate safeguards and to

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take all reasonable steps to prevent access to any PHI stored on the premises, including informing its workforce, contractors and vendors of the confidential nature of the records maintained by COUNTY. LICENSEE agrees to report to COUNTY within ten (10) calendar days any unauthorized use or any disclosure of PHI, which LICENSEE becomes aware. Upon COUNTY's knowledge of any breach, disclosure, or unauthorized use of PHI by LICENSEE, COUNTY shall:

a. Provide an opportunity for LICENSEE to cure the breach or end the violation. If LICENSEE does not cure the breach or end the violation within thirty (30) days or shorter period as required by COUNTY, COUNTY shall terminate this Agreement; or

b. Immediately terminate this Agreement if cure is not possible.

18. HAZARDOUS MATERIALS (AMLC-16.1 S)

A. Definition of Hazardous Materials. For purposes of this License, the term **"Hazardous Material"** or "Hazardous Materials" shall mean any hazardous or toxic substance, material, product, byproduct, or waste which is or shall become regulated by any governmental entity, including, without limitation, the COUNTY acting in its governmental capacity, the State of California or the United States government.

B. Use of Hazardous Materials. LICENSEE or LICENSEE's employees, agents, independent contractors or invitees (collectively **"LICENSEE Parties"**) shall not cause or permit any Hazardous Materials to be brought upon, stored, kept, used, generated, released into the environment or disposed of on, under, from or about the License Area (which for purposes of this clause shall include the subsurface soil and ground water). Notwithstanding the foregoing, LICENSEE may keep on or about the License Area small quantities of Hazardous Materials that are used in the ordinary, customary and lawful cleaning of and business operations on the License Area.

C. LICENSEE Obligations. If the presence of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties results in (i) injury to any person, (ii) injury to or contamination of the License Area (or a portion thereof), or (iii) injury to or contamination or any real or personal property wherever situated, LICENSEE, at its sole cost and expense, shall promptly take all actions necessary or appropriate to return the License Area to the condition existing prior to the introduction of such Hazardous Materials to the License Area and to remedy or repair any such injury or contamination. Without limiting any other rights or remedies of COUNTY under this License, LICENSEE shall pay the cost of any cleanup or remedial work performed on, under or about the License Area as required by this License or by applicable laws in connection with the removal, disposal, neutralization or other treatment of such Hazardous Materials caused or permitted by LICENSEE or LICENSEE Parties. Notwithstanding the foregoing, LICENSEE shall not take any remedial action in response to the presence, discharge or release, of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties, or enter into any settlement agreement, consent decree or other compromise with any governmental or quasigovernmental entity without first obtaining the prior written consent of the COUNTY. All work performed or caused to be performed by LICENSEE as provided for above shall be done in good and workmanlike manner and in compliance with plans, specifications, permits and other requirements for such work approved by COUNTY.

D. Indemnification for Hazardous Materials. To the fullest extent permitted by law, LICENSEE hereby agrees to indemnify, hold harmless, protect and defend (with attorneys acceptable to COUNTY) COUNTY, its elected officials, officers, employees, agents and independent contractors and the

License Area, from and against any and all liabilities, losses, damages (including, but not limited, damages for the loss or restriction on use of rentable or usable space or any amenity of the License Area or damages arising from any adverse impact on marketing of the License Area), diminution in the value of the License Area, judgments, fines, demands, claims, recoveries, deficiencies, costs and expenses (including, but not limited to, reasonable attorneys' fees, disbursements and court costs and all other professional or consultant's expenses), whether foreseeable or unforeseeable, arising directly or indirectly out of the presence, use, generation, storage, treatment, on or off-site disposal or transportation of Hazardous Materials on, into, from, under or about the License Area by LICENSEE or LICENSEE's Parties. The foregoing indemnity shall also specifically include the cost of any required or necessary repair, restoration, clean-up or detoxification of the License Area and the preparation of any closure or other required plans.

19. NOTICES (AMLC-14.1 S)

All notices pursuant to this License shall be addressed as set forth below or as either Party may hereafter designate by written notice and shall be sent through the United States mail in the State of California duly registered or certified with postage prepaid. If any notice is sent by registered or certified mail, as aforesaid, the same shall be deemed served or delivered twenty-four (24) hours after mailing thereof as above provided. Notwithstanding the above, COUNTY may also provide notices to LICENSEE by personal delivery, by regular mail, or by electric mail and any such notice so given shall be deemed to have been given upon receipt.

TO: COUNTY

County of Orange
Social Services Agency
Facilities Services
500 N. State College Boulevard
Orange, CA 92868

With a copy to:

County Executive Office
Attention: Chief Real Estate Officer
333 W. Santa Ana Boulevard, 3rd Floor
Santa Ana, CA 92701

TO: LICENSEE

CalOptima
15496 Magnolia, #111
Westminster, CA 92806
Phil Tsunoda, Executive Director,
Public Policy & Public Affairs
ptsunoda@caloptima.org

20. ATTACHMENTS TO LICENSE (AMLC-15.1 S)

This License includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
Exhibit A - License Description
Exhibit B – Floor Plan

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WITNESS WHEREOF, the parties have executed this License the day and year first above written

APPROVED AS TO FORM:
OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By _____
Deputy County Counsel

Date: 8/25/16

LICENSEE
CalOptima

By _____

Name: Michael Schrader
Title: CEO

RECOMMENDED FOR APPROVAL

Social Services Agency

By _____
Carol Wiseman, Chief Deputy Director

CEO Real Estate Services

By _____
John Buck, Administrative Manager

COUNTY

COUNTY OF ORANGE

By _____
Scott Mayer, Chief Real Estate Officer
County Executive Office
Per Resolution No. 14-014 of the Board of Supervisors and Minute Order dated January 28, 2014

Date: 8.29.16

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GENERAL CONDITIONS (AMLC-GC l-17 S)

1. PERMITS AND LICENSES (AMLC - GC2 S)

LICENSEE shall be required to obtain any and all permits and/or licenses which may be required in connection with the operation of the License Area as set out herein. No permit, approval, or consent given hereunder by COUNTY, in its governmental capacity, shall affect or limit LICENSEE's obligations hereunder, nor shall any approvals or consents given by COUNTY, as a Party to this License, be deemed approval as to compliance or conformance with applicable governmental codes, laws, rules, or regulations.

2. SIGNS (AMLC-GC3 S)

LICENSEE agrees not to construct, maintain, or allow any signs, banners, flags, etc., upon License Area except as approved by Facilities Operations Manager unapproved signs, banners, flags, etc., may be removed.

3. LICENSE ORGANIZATION (AMLC-GC4 S)

The various headings and numbers herein, the grouping of provisions of this License into separate clauses and paragraphs, and the organization hereof, are for the purpose of convenience only and shall not be considered otherwise.

4. AMENDMENTS (AMLC-GC5 S)

This License is the sole and only agreement between the Parties regarding the subject matter hereof; other agreements, either oral or written, are void. Any changes to this License shall be in writing and shall be properly executed by both Parties.

5. UNLAWFUL USE (AMLC-GC6 S)

LICENSEE agrees no improvements shall be erected, placed upon, operated, nor maintained on the License Area, nor any business conducted or carried on therein or there from, in violation of the terms of this License, or of any regulation, order of law, statute, bylaw, or ordinance of a governmental agency having jurisdiction.

6. INSPECTION (AMLC-GC7 S)

COUNTY or its authorized representative shall have the right at all reasonable times to inspect the operation to determine if the provisions of this License are being complied with.

7. INDEMNIFICATION (AMLC-GC8 S)

LICENSEE hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of persons or property arising from, growing out of, or in any way connected with or related to this License except claims arising from the concurrent active or sole negligence of COUNTY, its officers, agents, and employees. LICENSEE hereby agrees to indemnify, hold harmless, and defend with counsel acceptable to COUNTY, its officers, agents, and employees against any and all claims, loss, demands, damages, cost, expenses, or liability costs arising out of the operation, use, or maintenance of the property

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described herein, and/or LICENSEE's exercise of the rights under this License, except for liability arising out of the concurrent active or sole negligence of COUNTY, its officers, agents, or employees, including the cost of defense of any lawsuit arising there from.

In the event COUNTY is named as co-defendant, LICENSEE shall notify COUNTY of such fact and shall represent COUNTY with counsel acceptable to COUNTY in such legal action unless COUNTY undertakes to represent itself as co-defendant in such legal action, in which event LICENSEE shall pay to COUNTY its litigation costs, expenses, and attorney's fees. In the event judgment is entered against COUNTY and LICENSEE because of the concurrent active negligence of COUNTY and LICENSEE, their officers, agents, or employees, an apportionment of liability to pay such judgment shall be made by a court of competent jurisdiction. Neither Party shall request a jury apportionment.

8. TAXES AND ASSESSMENTS (AMLC-GC9 S)

Although not anticipated, should this License create a possessory interest which is subject to the payment of taxes levied on such interest, it is understood and agreed that all taxes and assessments (including but not limited to said possessory interest tax) which become due and payable in connection with this License or upon fixtures, equipment, or other property used in connection with this License, shall be the full responsibility of LICENSEE, and LICENSEE shall cause said taxes and assessments to be paid promptly.

9. PARTIAL INVALIDITY (AMLC-GC10 S)

If any term, covenant, condition, or provision of this License is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

10. WAIVER OF RIGHTS (AMLC-GC11 S)

The failure of COUNTY to insist upon strict performance of any of the terms, covenants, or conditions of this License shall not be deemed a waiver of any right or remedy that COUNTY may have, and shall not be deemed a waiver of the right to require strict performance of all the terms, covenants, and conditions of the License thereafter, nor a waiver of any remedy for the subsequent breach or default of any term, covenant, or condition of the License. Any waiver, in order to be effective, must be signed by the Party whose right or remedy is being waived.

11. CONDITION OF LICENSE AREA UPON TERMINATION (AMLC-GC12 S)

Except as otherwise agreed to herein, upon termination of this License, LICENSEE shall redeliver possession of said License Area to COUNTY in substantially the same condition that existed immediately prior to LICENSEE's entry thereon, reasonable wear and tear, flood, earthquakes, and any act of war excepted.

12. DISPOSITION OF ABANDONED PERSONAL PROPERTY (AMLC-GC13 S)

If LICENSEE abandons the License Area or is dispossessed thereof by process of law or otherwise, title to any personal property belonging to LICENSEE and left on the License Area ten (10) days after such event shall be deemed, at COUNTY's option, to have been transferred to COUNTY. COUNTY shall have the

right to remove and to dispose of such property without liability there from to LICENSEE or to any person claiming under LICENSEE, and shall have no need to account therefore.

13. TIME OF ESSENCE (AMLC-GC14 S)

Time is of the essence of this License. Failure to comply with any time requirements of this License shall constitute a material breach of this License.

14. NO ASSIGNMENT (AMLC-G15 S)

The License granted hereby is personal to LICENSEE and any assignment of said license by LICENSEE, voluntarily or by operation of law, shall automatically terminate the License granted hereby.

15. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (AMLC-GC16 S)

In order to comply with child support requirements of the County of Orange, LICENSEE hereby furnishes COUNTY's Facilities Operations Manager, COUNTY's standard form, Child Support Enforcement Certification Requirements. COUNTY acknowledges receipt of the aforementioned form, which contains the following information:

a) In the case where LICENSEE is doing business as an individual, LICENSEE's name, date of birth, Social Security number, and residence address;

b) In the case where LICENSEE is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;

c) A certification that LICENSEE has fully complied with all applicable federal and state reporting requirements regarding its employees; and

d) A certification that LICENSEE has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment and will continue to so comply.

Failure of LICENSEE to continuously comply with all federal and state reporting requirements for child support enforcement or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment shall constitute a material breach of this License. Failure to cure such breach within sixty (60) calendar days of notice from COUNTY's shall constitute grounds for termination of this License.

It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders and will not be used for any other purpose.

16. RIGHT TO WORK AND MINIMUM WAGE LAWS (AMLC-GC17 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LICENSEE shall require its employees that directly or indirectly service the License Area or terms and conditions of this License, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LICENSEE shall also require and verify that its contractors or any other persons servicing the License Area

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or terms and conditions of this License, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LICENSEE shall pay no less than the greater of the Federal or California Minimum Wage to all its employees that directly or indirectly service the License Area, in any manner whatsoever. LICENSEE shall require and verify that all its contractors or other persons servicing the License Area on behalf of LICENSEE also pay their employees no less than the greater of the Federal or California Minimum Wage.

LICENSEE shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the License Area or terms and conditions of this License.

Notwithstanding the minimum wage requirements provided for in this clause, LICENSEE, where applicable, shall comply with the prevailing wage and related requirements pursuant to the provisions of Section 1773 of the Labor Code of the State of California.

17. BEST MANAGEMENT PRACTICES (AMLC 15.1 S)

LICENSEE and all of LICENSEE's, agents, employees and contractors shall conduct operations under this License so as to assure that pollutants do not enter municipal storm drain systems which systems are comprised of, but are not limited to curbs and gutters that are part of the street systems ("**Stormwater Drainage System**"), and to ensure that pollutants do not directly impact "**Receiving Waters**" (as used herein, Receiving Waters include, but are not limited to, rivers, creeks, streams, estuaries, lakes, harbors, bays and oceans).

The Santa Ana and San Diego Regional Water Quality Control Boards have issued National Pollutant Discharge Elimination System ("**NPDES**") permits ("**Stormwater Permits**") to the County of Orange, and to the Orange County Flood Control District and cities within Orange County, as co-permittees (hereinafter collectively referred to as "**County Parties**") which regulate the discharge of urban runoff from areas within the County of Orange, including the License Area. The County Parties have enacted water quality ordinances that prohibit conditions and activities that may result in polluted runoff being discharged into the Stormwater Drainage System.

To assure compliance with the Stormwater Permits and water quality ordinances, the County Parties have developed a Drainage Area Management Plan ("**DAMP**") which includes a Local Implementation Plan ("**LIP**") for each jurisdiction that contains Best Management Practices ("**BMP(s)**") that parties using properties within Orange County must adhere to. As used herein, a BMP is defined as a technique, measure, or structural control that is used for a given set of conditions to manage the quantity and improve the quality of stormwater runoff in a cost effective manner. These BMPs are found within the COUNTY's LIP in the form of Model Maintenance Procedures and BMP Fact Sheets (the Model Maintenance Procedures and BMP Fact Sheets contained in the DAMP/LIP shall be referred to hereinafter collectively as "**BMP Fact Sheets**") and contain pollution prevention and source control techniques to eliminate non-stormwater discharges and minimize the impact of pollutants on stormwater runoff.

The use under this License does not require BMP Fact Sheets.

18. PAYMENT CARD COMPLIANCE (AMLC-G15 S)

Should LICENSEE conduct credit/debit card transactions in conjunction with their business with the COUNTY, on behalf of the COUNTY, or as part of the business that they conduct, LICENSEE covenants and warrants that it is currently Payment Card Industry Data Security Standard (**"PCI DSS"**) and Payment Application Data Security Standards (**"PA DSS"**) compliant and will remain compliant during the entire duration of this License. LICENSEE agrees to immediately notify COUNTY in the event LICENSEE should ever become non-compliant, and will take all necessary steps to return to compliance and shall be compliant within ten (10) days of the commencement of any such interruption.

Upon demand by COUNTY, LICENSEE shall provide to COUNTY written certification of LICENSEE's PCI DSS and/or PA DSS compliance.

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LICENSE DESCRIPTION (10.1 S)

PROJECT NO: GA 1213-236 DATE: 6/29/16

PROJECT: CalOptima
15496 Magnolia, #111
Westminster, CA 92806

WRITTEN BY: EAS

All the License Area referenced on a Floor Plan marked Exhibit B, attached hereto and made a part hereof, being approximately Three Hundred Sixty Two (362) rentable square feet of COUNTY-designated space for LICENSEE's non-exclusive use, which space may vary from time-to-time based on COUNTY's pre-approval in writing, and being a portion of the Orange County Community Service Center Annex building located at 15496 Magnolia, Suite 111, Rooms 1 and 2 in the City of Westminster, County of Orange, State of California, together with appurtenant right to use common areas located thereon, and the non-exclusive use of one parking space in the adjacent parking lot.

NOT TO BE RECORDED

EXHIBIT A

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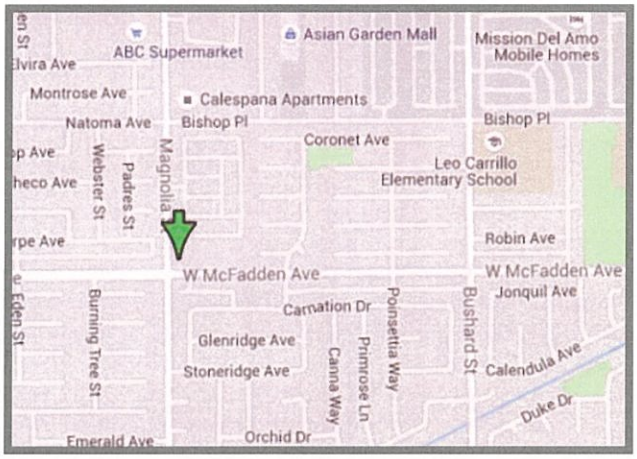
GA 1213-237
SSA/CalOptima



Location Map

N

License Area:
Rooms 1 & 2

15496 Magnolia St. Suite 111 Westminster Ca. 92683

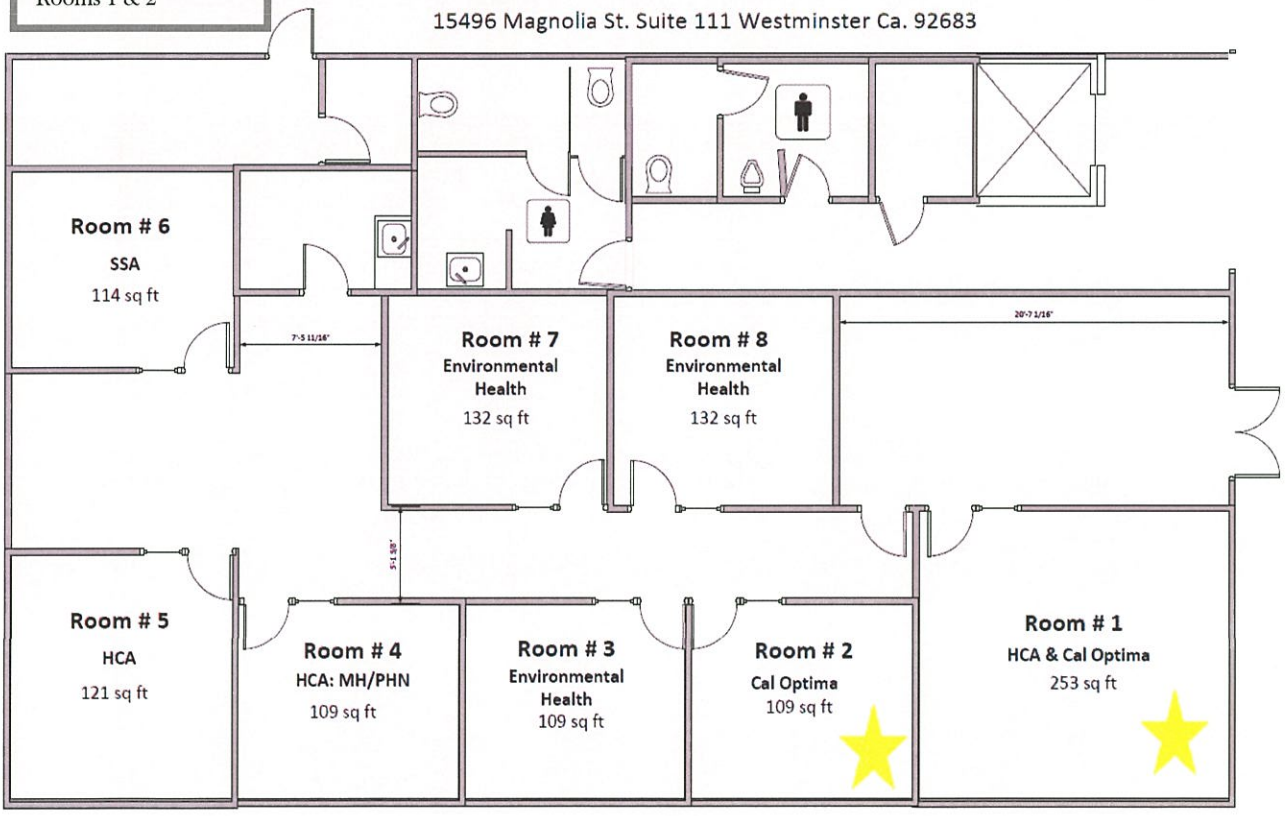


EXHIBIT B

CCSC COST APPLY - 15496 Magnolia Street, Westminster

FY 2017-18 MONTHLY INVOICE CODING SUMMARY

Invoice Coding and Job Number Allocation.

	Fund/Dept/Budget Control Unit/Object/Job No.	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
CalOptima	100/063/063 2211/2200/S34009	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	**$ 18,731.77**

LEASED SPACE

	Fund/Dept/Budget Control /Unit/Object/Job No	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/2200/S34009**	**235.55**	**21.83%**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 17,090.27**

Total leased space: 1079 sq. ft.

Lease rates: Monthly Fiscal Year total:

Rent: July 1, 2017 - June 30, 2018 $ 6,524.00 $ 78,288.00

Operating Expenses

charge by Charles H Manh and Anh Manh	Fund/Dept/Budget Control /Unit/Object/Job No	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/1000/S34009**	**235.55**	**21.83%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Total leased space: 1079 sq. ft.

Monthly Fiscal Year total:

Operating Expenses: July 1 2017 - June 30, 2018 $ - $ -

IT SERVICES - Internet by Time W

	Fund/Dept/Budget Control /Unit/Object	# computers	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/1000/S34009**	**1**	**16.67%**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 790.02**

Monthly IT rates $ 395.01 2016-17 Rate + 2.60% CPI

Annual High Speed Internet Service Cost $ 4,740.12

TELEPHONE SERVICES

	Fund/Dept/Budget Control /Unit/Object	# phones	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/1000/S34009**	**1**	**12.50%**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 231.25**

Monthly Average Telephone Service Costs $ 154.17 2016-17 Rate + 2.60% CPI

Annual Telephone Service Costs $ 1,850.00

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JANITORIAL SERVICES	Fund/Dept/Budget Control /Unit/Object	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total		
Cal Optima	**100/063/063 2211/1000/S34009**	**235.55**	**21.83%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		

Total leased space: 1079 sq. ft.

Monthly Janitorial Costs $ - 2016-17 Rate + 2.60% CPI
12 mo. Annual Janitorial Costs $ -

ELECTRICAL/UTILITIES Acct 3045332860 by Al Pasillas	Fund/Dept/Budget Control /Unit/Object	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total		
Cal Optima	**100/063/063 2211/1000/S34009**	**235.55**	**21.83%**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 620.23**		

Total leased space: 1079 sq. ft.

Average Utility Costs $ 236.76 2016-17 Rate + 2.60% CPI
12 mo. Annual Janitorial Costs $ 2,841.17

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FIRST AMENDMENT TO LICENSE

This FIRST AMENDMENT TO LICENSE AGREEMENT (**"First Amendment"**) is made and entered into August 23, 2017, by and between CALOPTIMA (hereinafter referred to as **"LICENSEE"**) and COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**) without regard to number and gender. LICENSEE and COUNTY may individually be referred to herein as a "**Party**" or collectively as the "**Parties**."

RECITALS

I. COUNTY leases that certain real property located at 15496 Magnolia in the City of Westminster, State of California, License Area, pursuant to a lease dated July 1, 2016 for COUNTY's Social Services Agency's (**"SSA"**) Orange County Community Service Center Annex (**"OCCSCA"**).

II. The term of this License commenced on August 4, 2016, and will terminate on June 30, 2017.

III. The Parties have agreed to amend the License to extend the term for four (4) additional years.

NOW, THEREFORE, in consideration of the Recitals, above, incorporated by reference herein, and the mutual covenants and agreements hereinafter contained, COUNTY and LICENSEE mutually agree to amend the License effective July 1, 2017 (**"Effective Date"**) as follows:

A. Clause 2. [TERM (AMLC-3.1N)] is hereby deleted in its entirety from the License and replaced with the following:

"2. TERM (AMLC-3.1 N)

The term of this License commenced on August 4, 2016 and shall terminate on June 30, 2021 ("**Term**"). Said License shall continue in effect for the Term, unless otherwise terminated as provided in Clause 3 (TERMINATION) of this License.

B. Clause 4. [LICENCE AREA (AMLC-4.2N)] is hereby deleted in its entirety from the License and replaced with the following:

"4. LICENSE AREA (AMLC-4.2 N)

COUNTY grants to LICENSEE the exclusive right to use that certain property referred to as Room #2 and non-exclusive right to use that certain property referred to as Room #1. hereinafter referred to as **"License Area,"** described on Revised Exhibit A and shown on Exhibit B, attached hereto and by reference made a part hereof, for the purposes set forth in Clause 6 (USE) of this License together with non-exclusive, in common use of COUNTY's elevators, stairways, washrooms, hallways, driveways for vehicle ingress and egress, parking, pedestrian walkways, other facilities and common areas appurtenant to LICENSEE's License Area created by this License.

During the term of this License, the dates and times for use of Room #1of the License Area will be determined by the Facilities Services Manager to ensure LICENSEE has access to Room #1 for fifty percent (50%) of the time, and the location of Room #2 as shown on Exhibit B of the License Area is subject to relocation at the sole discretion of the Facilities Operations Manager.

C. Clause 6. [USE (AMLC-5.1 N)] is hereby deleted in its entirety from the License and replaced with the following:

"6. USE (AMLC-5.1 N)

LICENSEE's use of the License Area shall be limited to general office to provide clients with health related workshops and information regarding their CalOptima Programs, to store CalOptima materials, and to provide private space to meet with CalOptima Members or potential members.

LICENSEE agrees not to use the License Area for any other purpose nor to engage in or permit any other activity within or from the License Area without prior written permission from the Facilities Services Manager. LICENSEE further agrees not to conduct or permit to be conducted any public or private nuisance in, on, or from the License Area, not to commit or permit to be committed waste on the License Area, and to comply with all governmental laws and regulations in connection with its use of the License Area.

D. Clause 7. [LICENCE FEE (AMLC-6.1S)] is hereby deleted in its entirety from the License and replaced with the following:

"7. LICENSE FEE (AMLC-6.1 S)

LICENSEE agrees to pay COUNTY from and after the Effective Date of this License according to the following schedule:

Commencing	Monthly License Fee
July 1, 2017	$1,560.98
July 1, 2018	$1,607.81
July 1, 2019	$1,656.04
July 1, 2020	$1,705.72

The monthly License Fee shall be payable in advance, without prior notice or demand on the first day of each calendar month while this License is in effect without deduction or offset in lawful money of the United States.

In the event the obligation to pay the License Fee begins or terminates on some day other than the first day or last day of the month, the License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month.

E. Clause 10. [UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N) is hereby deleted in its entirety from the License and replaced with the following:

"10. UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N)

COUNTY shall be responsible for all charges for all utilities (water, gas, electricity and sewer). County shall be responsible for all maintenance and repairs (including but not limited to: fire alarm, fire extinguisher, HVAC system, elevator maintenance, landscaping, pest control, and trash). LICENSEE shall be responsible for telephone service, internet service and janitorial service.

F. Clause 14. [INSURANCE (AML-10.1S)] is hereby deleted in its entirety from the License and replaced with the following:

"14. INSURANCE (AML-6.1 S)

LICENSEE agrees to purchase all required insurance at LICENSEE's expense and to deposit with the COUNTY certificates of insurance, including all endorsements required herein, necessary to satisfy the COUNTY that the insurance provisions of this License have been complied with and to keep such insurance coverage and the certificates and endorsements therefore on deposit with the COUNTY during the entire term of this License.

LICENSEE agrees that LICENSEE shall not operate on the License Area at any time the required insurance is not in full force and effect as evidenced by a certificate of insurance and necessary endorsements or, in the interim, an official binder being in the possession of Facilities Service Manager. In no cases shall assurances by LICENSEE, its employees, agents, including any insurance agent, be construed as adequate evidence of insurance. Facilities Service Manager will only accept valid certificates of insurance and endorsements, or in the interim, an insurance binder as adequate evidence of insurance. LICENSEE also agrees that upon cancellation, termination, or expiration of LICENSEE's insurance, COUNTY may take whatever steps are necessary to interrupt any operation from or on the License Area until such time as the Facilities Service Manager reinstates the License.

If LICENSEE fails to provide Facilities Service Manager with a valid certificate of insurance and endorsements, or binder at any time during the term of the License, COUNTY and LICENSEE agree that this shall constitute a material breach of the License. Whether or not a notice of default has or has not been sent to LICENSEE, said material breach shall permit COUNTY to take whatever steps necessary to interrupt any operation from or on the License Area, and to prevent any persons, including, but not limited to, members of the general public, and LICENSEE's employees and agents, from entering the License Area until such time as Facilities Service Manager is provided with adequate evidence of insurance required herein. LICENSEE further agrees to hold COUNTY harmless for any damages resulting from such interruption of business and possession, including, but not limited to, damages resulting from any loss of income or business resulting from the COUNTY's action.

LICENSEE may occupy the [Premises] only upon providing to County the required insurance stated herein and maintain such insurance for the entire term of this LICENSE. County reserves the right to terminate this LICENSE at any time LICENSEE's insurance is canceled or terminated and not reinstated within ten (10) days of said cancellation or termination. LICENSEE shall provide to County immediate notice of said insurance cancellation or termination.

All contractors performing work on behalf of LICENSEE pursuant to this License shall obtain insurance subject to the same terms and conditions as set forth herein for LICENSEE. LICENSEE shall not allow contractors or subcontractors to work if contractors have less than the level of coverage required by the COUNTY from the LICENSEE under this License. It is the obligation of the LICENSEE to provide written notice of the insurance requirements to every contractor and to receive proof of insurance prior to allowing any contractor to begin work within the License Area. Such proof of insurance must be maintained by LICENSEE through the entirety of this License and be available for inspection by a COUNTY representative at any reasonable time.

All self-insured retentions (SIRs) shall be clearly stated on the Certificate of Insurance. Any self-insured retention (SIR) in an amount in excess of Fifty Thousand Dollars ($50,000) shall specifically be approved by the County's Risk Manager, or designee, upon review of LICENSEE's current audited financial report. If LICENSEE's SIR is approved, LICENSEE, in addition to, and without limitation of, any other indemnity provision(s) in this License, agrees to all of the following:

1) In addition to the duty to indemnify and hold the County harmless against any and all liability, claim, demand or suit resulting from LICENSEE's, its agents, employee's or subcontractor's performance of this Agreement, LICENSEE shall defend the County at its sole cost and expense with counsel approved by Board of Supervisors against same; and
2) LICENSEE's duty to defend, as stated above, shall be absolute and irrespective of any duty to indemnify or hold harmless; and
3) The provisions of California Civil Code Section 2860 shall apply to any and all actions to which the duty to defend stated above applies, and the LICENSEE's SIR provision shall be interpreted as though the LICENSEE was an insurer and the County was the insured.

If the LICENSEE fails to maintain insurance acceptable to the COUNTY for the full term of this License, the COUNTY may terminate this License.

Qualified Insurer

The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by the LICENSEE shall provide the minimum limits and coverage as set forth below:

Coverages	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence

Coverages	Minimum Limits
	$2,000,000 aggregate
Automobile Liability including coverage for owned, non-owned and hired vehicles	$1,000,000 limit per occurrence
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence
Commercial Property Insurance on an "All Risk" or "Special Causes of Loss" basis covering all, contents and any tenant improvements including Business Interruption/Loss of Rents with a 12 month limit.	100% of the Replacement Cost Value and no coinsurance provision

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (ISO) form CG 00 01, or a substitute form providing liability coverage at least as broad.

The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing liability coverage as broad.

Required Endorsements

The Commercial General Liability policy shall contain the following endorsements, which shall accompany the Certificate of insurance:

1) An Additional Insured endorsement using ISO form CG 20 26 04 13 or a form at least as broad naming the ***County of Orange, its elected and appointed officials, officers, employees, agents*** as Additional Insureds. Blanket coverage may also be provided which will state- ***As Required By Written Agreement***.
2) A primary non-contributing endorsement using ISO form CG 20 01 04 13, or a form at least as broad, evidencing that the LICENSEE's insurance is primary and any insurance or self-insurance maintained by the County of Orange shall be excess and non-contributing.

The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the ***County of Orange, its elected and appointed officials, officers, agents and employees***. Blanket coverage may also be provided which will state- ***As Required By Written Agreement.***

All insurance policies required by this license shall waive all rights of subrogation against the County of Orange, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

The Commercial Property policy shall contain a Loss Payee endorsement naming the County of Orange as respects the County's financial interest when applicable.

LICENSEE shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the LICENSE, upon which the County may suspend or terminate this LICENSE.

The Commercial General Liability policy shall contain a severability of interests clause, also known as a "separation of insureds" clause (standard in the ISO CG 001 policy).

Insurance certificates should be forwarded to the COUNTY address provided in the Clause (NOTICES) below or to an address provided by Facilities Service Manager. LICENSEE has ten (10) business days to provide adequate evidence of insurance or this License may be cancelled.

COUNTY expressly retains the right to require LICENSEE to increase or decrease insurance of any of the above insurance types throughout the term of this License. Any increase or decrease in insurance will be as deemed by County of Orange Risk Manager as appropriate to adequately protect COUNTY.

COUNTY shall notify LICENSEE in writing of changes in the insurance requirements. If LICENSEE does not deposit copies of acceptable certificates of insurance and endorsements with COUNTY incorporating such changes within thirty (30) days of receipt of such notice, this License may be in breach without further notice to LICENSEE, and COUNTY shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit LICENSEE's liability hereunder nor to fulfill the indemnification provisions and requirements of this License, nor in any way to reduce the policy coverage and limits available from the insurer.

G. Clause 17. [HIPAA (N)] is hereby deleted from the License in its entirety.

H. Clause 18. [HAZARDOUS MATERIALS (AMLC-16.1S)] is hereby deleted from the License in its entirety.

I. Clause 19. [NOTICES (AMLC-14.1S)] is hereby deleted from the License in its entirety and replaced with the following:

"19. NOTICES (AMLC-14.1 S)

All notices pursuant to this License shall be addressed as set forth below or as either Party may hereafter designate by written notice and shall be sent through the United States mail in the State of California duly registered or certified with postage prepaid. If any notice is sent by registered or certified mail, as aforesaid, the same shall be deemed served or delivered twenty-four (24) hours after mailing thereof as above provided. Notwithstanding the above, COUNTY may also provide notices to LICENSEE by personal delivery, by regular mail, or by electric mail and any such notice so given shall be deemed to

have been given upon receipt.

TO: COUNTY	TO: LICENSEE
County of Orange Social Services Agency Facilities Services 500 N. State College Boulevard Orange, CA 92868 Attention: Facilities Services Manager	CalOptima 505 City Parkway West Orange, CA 92868 Attention: Chief Executive Officer mschrader@caloptima.org
With a copy to:	With a copy to:
County Executive Office 333 W. Santa Ana Boulevard, 3rd Floor Santa Ana, CA 92701 Attention: Chief Real Estate Officer	CalOptima 505 City Parkway West Orange, CA 92868 Attention: Legal Counsel gcrockett@caloptima.org

J. Clause 20. [ATTACHMENTS TO LICENSE (AMLC-15.1S)] is hereby deleted from the License in its entirety and replaced with the following:

"**20. ATTACHMENTS TO LICENSE (AMLC-15.1 S)**

This License includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
Revised Exhibit A - License Description
Exhibit B – Floor Plan

K. Wherever a conflict in the terms or conditions of this First Amendment and the License exists, the terms or conditions of this First Amendment shall prevail. In all other respects, the terms and conditions of the License not specifically changed by this First Amendment shall remain in full force and effect.

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IN WITNESS WHEREOF, the Parties have executed this First Amendment the day and year first above written.

APPROVED AS TO FORM:

OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By _____
Deputy

Date: 8/21/17

LICENSEE
CALOPTIMA

By _____
Name: Michael Schrader
Title: CEO

RECOMMENDED FOR APPROVAL

SOCIAL SERVICES AGENCY

By _____
Carol Wiseman, Chief Deputy Director

COUNTY

COUNTY OF ORANGE

By _____
Scott Mayer, Chief Real Estate Officer
County Executive Office
Per Resolution No. 14-014 of the Board of Supervisors and Minute Order dated January 28, 2014

Date: 8.23.17

COUNTY EXECUTIVE OFFICE

By _____
Administrative Manager
Real Estate Services

REVISED EXHIBIT A

LICENSE DESCRIPTION (10.1 S)

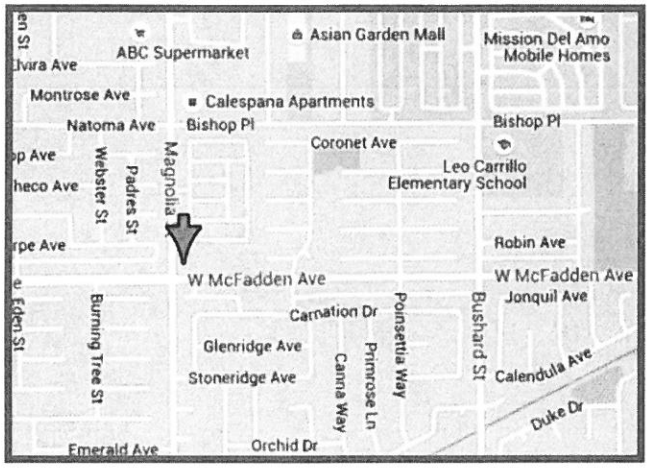
PROJECT NO: GA 1213-236 DATE: 6/13/17

PROJECT: CalOptima
15496 Magnolia, #111
Westminster, CA 92806

WRITTEN BY: EAS

All the License Area referenced on a Floor Plan marked Exhibit B, attached hereto and made a part hereof, being a total of Three Hundred Sixty Two (362) rentable square feet of COUNTY-designated space for LICENSEE's use, which consists of approximately One Hundred Nine (109) rentable square feet identified as Room #2 that shall be exclusive to LICENSEE, and the remaining Two Hundred Fifty Three (253) rentable square feet shall be non-exclusive, identified as Room #1. License Area may vary from time-to-time based on COUNTY's pre-approval in writing, and being a portion of the Orange County Community Service Center Annex building located at 15496 Magnolia, Suite 111, Rooms 1 and 2 in the City of Westminster, County of Orange, State of California, together with appurtenant right to use common areas located thereon, and the non-exclusive use of one parking space in the adjacent parking lot. The parties acknowledge that in the event Room #1 is expanded to include the common area immediately adjacent, such expanded area shall be included in the License Area.

NOT TO BE RECORDED



Location Map

N

License Area:
Rooms 1 & 2

15496 Magnolia St. Suite 111 Westminster Ca. 92683

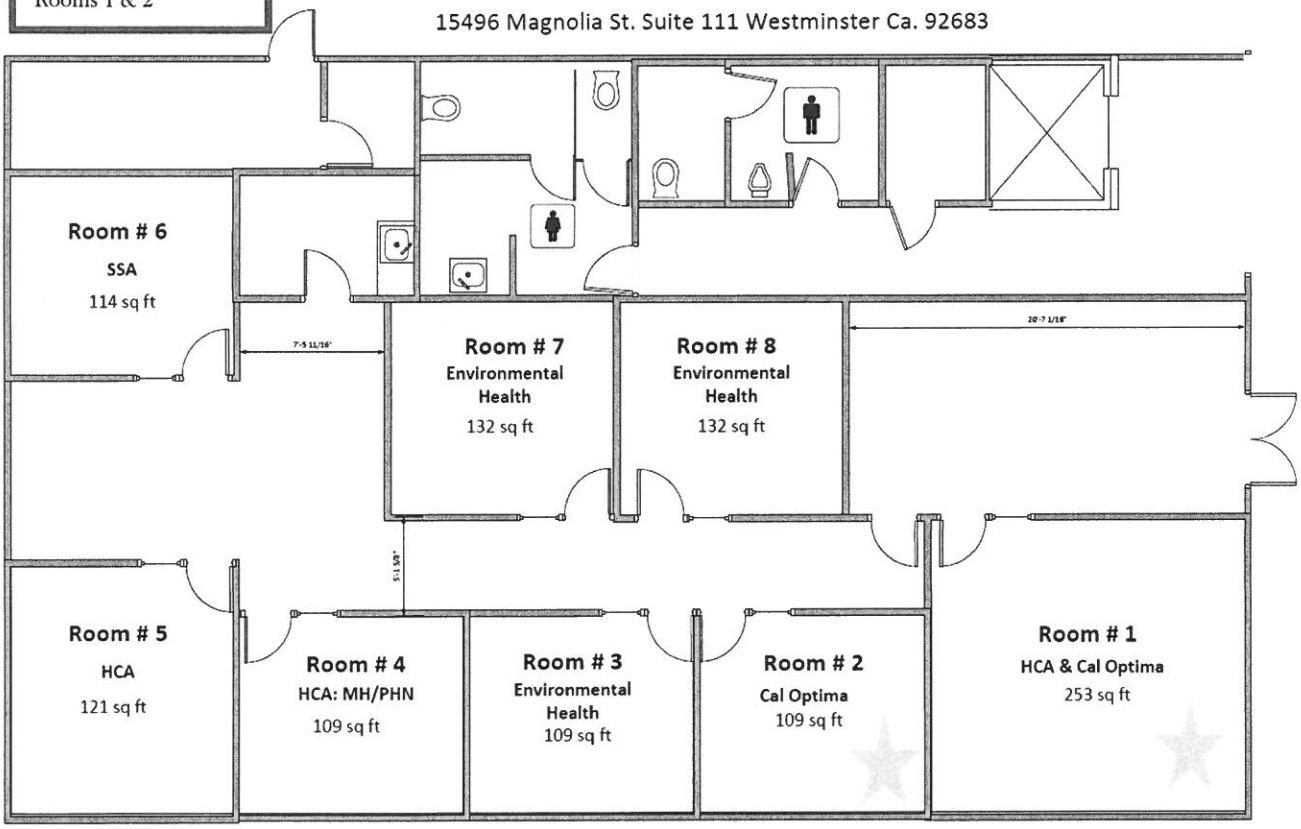


EXHIBIT B

Attachment F

West Annex Community Customer Service Center
15496 Magnolia Street
Westminster, CA 92683

~~LEASE~~FIRST AMENDMENT TO LEASE

THIS FIRST AMENDMENT TO LEASE (**"First Amendment"**) is made _____, 2017 (**"Effective Date"**) by and between CHARLES H. MANH and ANH MANH, Co-Trustees of the MANH FAMILY TRUST, under declaration of trust dated August 15, 2006, (hereinafter referred to as **"LESSOR"**), and the COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**), without regard to number and gender. LESSOR and COUNTY may individually be referred to herein as a "**Party"** and collectively as the **"Parties."**

~~THIS IS A LEASE (hereinafter referred to as "**Lease**"), made July 1, 2016, ("**Effective Date**") by and between CHARLES H. MANH and ANH MANH, Co-Trustees of the MANH FAMILY TRUST, under declaration of trust dated August 15, 2006 ("**LESSOR**") and the COUNTY OF ORANGE, a political subdivision of the State of California ("**COUNTY**"), without regard to number and gender. The LESSOR and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**.~~

R E C I T A L S

I. Pursuant to a lease agreement dated July 1, 2016 (**"Lease"**), LESSOR leases to COUNTY approximately 2,120 rentable square feet of office space (**"Premises"**) in the building located at 15496 Magnolia Street, in the City of Westminster, California (**"Building"**) for use by the Social Services Agency, which Premises is more particularly described on Exhibit A and Exhibit B of the Lease.

II. The original Lease term of one (1) year commenced on July 1, 2016.

III. LESSOR and COUNTY are willing to amend the Lease to extend the term of the Lease for an additional four (4) years through June 30, 2021 under the terms and conditions set forth below.

1. DEFINITIONS (1.2 S)

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

"CEO Real Estate"" means the County Executive Office's Real Estate team, or upon written notice to LESSOR, such other person or entity as shall be designated by the Chief Real Estate Officer, County of Orange, or designee.

"Chief Real Estate Officer" means the Chief Real Estate Officer for the County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or r the Board of Supervisors.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

"Risk Manager" means the Risk Manager, County Executive Office, Risk Management, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. PREMISES (1.3 S)

LESSOR leases to COUNTY that certain property consisting of 2,120 square feet, located at 15496 Magnolia Street, Suite 111, Westminster, CA and described in Exhibit A and shown on Exhibit B, which exhibits are attached hereto and by reference made a part hereof (hereinafter referred to as "**Premises**"),, together with non-exclusive, in common use of LESSOR's elevators, stairways, washrooms, hallways, parking areas, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to the Premises created by this Lease.

3. PARKING (1.4 S)

LESSOR, throughout the term of this Lease, shall provide a total of thirteen (13) parking spaces for COUNTY's free and non-exclusive use. Said parking spaces are to be located in the parking areas adjacent to the Premises. LESSOR shall designate three (3) parking spaces adjacent to the Premises to be reserved for use by COUNTY clients. Said parking spaces shall contain signs above the space indicating that the spaces are reserved for COUNTY use.

In addition to said parking spaces, LESSOR shall also provide parking for disabled persons in accordance with the Americans with Disabilities Act, Section 7102 of the California Uniform Building Code and the applicable codes and/or ordinances relating to parking for disabled persons as established by the local

jurisdiction in which the Premises is located where the provisions of such local codes and/or ordinances exceed or supersede the State requirements.

A. Clause 4. TERM (2.2 N) is hereby deleted in its entirety from the Lease and replaced with the following:

4. TERM (2.2 N)

The term of this Lease commenced on July 1, 2016 (**"Commencement Date"**), and will terminate on June 30, 2021 (**"Term"**).~~"The term of this Lease shall be one (1) year ("**Term**"), commencing upon the first of the next month following execution of this Lease by the COUNTY Chief Real Estate Officer or upon LESSOR's delivery and COUNTY's acceptance of the Premises, whichever is later ("**Commencement Date**").~~

~~Parties agree that the Commencement Date of this Lease will be confirmed in writing by either Party upon demand by the other.~~

B. Clause 5. RENT (3.1 N) is hereby deleted in its entirety from the Lease and replaced with the following:

5. RENT (3.1 N)

~~COUNTY agrees to pay LESSOR as rent for the Premises the sum of Five Thousand Dollars ($5,000.00) per month~~ ~~pursuant to the following rent payment schedule ("**Rent**").~~

~~MONTH~~	~~MONTHLY RENT~~	~~MONTH~~	~~MONTHLY RENT~~
~~1~~	~~$0.00~~	~~7~~	~~$5,000.00~~
~~2~~	~~$0.00~~	~~8~~	~~$5,000.00~~
~~3~~	~~$5,000.00~~	~~9~~	~~$5,000.00~~
~~4~~	~~$5,000.00~~	~~10~~	~~$5,000.00~~
~~5~~	~~$5,000.00~~	~~11~~	~~$5,000.00~~
~~6~~	~~$5,000.00~~	~~12~~	~~$5,000.00~~

The monthly rent payable by COUNTY for the Premises shall be automatically adjusted as follows:

Commencing	Monthly Rent	Per Square Foot
July 1, 2017	$6,524	$3.08
July 1, 2018	$6,720	$3.17
July 1, 2019	$6,921	$3.26
July 1, 2020	$7,129	$3.36

The "Monthly Rent," above, is the amount to be paid by the COUNTY. The "Per Square Foot" rate, above, is an estimate for statistical purposes only and for no other purpose.

To obtain rent payments LESSOR (or LESSOR's designee) shall submit to the COUNTY, in a form acceptable to said COUNTY, a written claim for payment of applicable Rent and COUNTY's share of the NNN Expenses, as defined in Section 6, below.

Payment shall be due and payable by direct deposit into a bank account specified by LESSOR within twenty (20) days after the later of the following:

A. The first day of the month following the month earned; or
B. Receipt of LESSOR's written claim by COUNTY.

Should COUNTY occupy the Premises before the Commencement Date, LESSOR shall be entitled to pro rata Rent for the period of occupancy occupied prior to the Commencement Date based upon the monthly Rent above. Said Rent shall be included in the rent claim submitted by LESSOR for the first full month of the Term and shall be paid by COUNTY at the time of payment for said month.

6. REIMBURSEMENT OF LESSOR'S OPERATING EXPENSES (6.0 N)

LESSOR and COUNTY agree pursuant to Section 5, above, that COUNTY shall pay the fixed amount of $657.20 ($.31/sf/mo.) per month for the term of the lease, as reimbursement for COUNTY's pro rata share of LESSOR's expenses related to the items described in Section 6A, 6B, 6C and 6D of this Lease for the property in which the Premises is located ("**NNN Expenses**"). LESSOR shall submit to COUNTY a separate monthly invoice .in addition to the monthly Rent invoice.

The pro rata share of LESSOR's NNN Expenses as defined above is determined according to the gross leasable area of the Premises as it relates to the total gross leasable area of the building that contains the Premises. The percent of COUNTY's occupancy which LESSOR and COUNTY agree is 12.47% (the "**pro rata share**"): the Premises is 2,120 gross square feet; and the total building area is 17,000 gross square feet.

COUNTY shall reimburse LESSOR for COUNTY's pro rata share of the NNN Expenses only for the items in Section 6A, 6B and 6C and 6D below:

A. Property Taxes and Property Tax Assessments pursuant to Section 13 of this Lease.
B. Maintenance and repair, and janitorial services for the common area restrooms in the building in which the Premises is located pursuant to Section 9 of this Lease.
C. Common area maintenance and repair of the building, parking lots, landscaping, lighting, and other common area maintenance and repair costs pursuant to Section 9 of this Lease.
D. Commercial Property Insurance and Commercial General Liability Insurance pursuant to Section 11 of this Lease.

7. ALTERATIONS (4.4 S)

COUNTY may make improvements and changes in the Premises, including but not limited to the installation of fixtures, partitions, counters, shelving, and equipment as deemed necessary or appropriate. It is agreed that any such fixtures, partitions, counters, shelving, or equipment attached to or placed upon the Premises by COUNTY shall be considered as personal property of COUNTY, who shall have the right to remove same. COUNTY agrees that the Premises shall be left in as good condition as when received, reasonable wear and tear excepted.

8. ORANGE COUNTY INFROMATION TECHNOLOGY SYSTEM S (OCIT) (4.5 N)

LESSOR agrees that COUNTY may install, at COUNTY's sole cost and expense, computer and telecommunication devices in, on, or around the Premises and LESSOR's building in accordance with COUNTY's plans and specifications provided that the provisions of the Clause entitled ALTERATIONS, of this Lease, shall be applicable to such work. It shall be COUNTY's responsibility to obtain all governmental permits and/or approvals required for such installation; however, LESSOR shall reasonably cooperate with COUNTY as necessary or appropriate, to obtain said permits and/or approvals.

9. Clause 9. REPAIR, MAINTENANCE, AND JANITORIAL SERVICES (5.1 S) is hereby deleted from the Lease and the following is substituted:

"9. REPAIR, MAINTENANCE, AND JANITORIAL SERVICES (5.1 N)

1. **Lessor Services.** LESSOR shall provide, at its sole cost and expense, except as otherwise provided in this Lease, any and all necessary repair, maintenance and replacement for the Premises and Building and systems therein in good order, condition and repair and in compliance with all applicable laws, including, but not limited to, the replacement, repair and maintenance of the structural portions of the Building, the roof of the Building, the parking facilities and all Building systems including the Heating, Ventilation, Air Conditioning (**"HVAC"**) system, the plumbing

with the exception that COUNTY shall reimburse LESSOR for any expense incurred for repairing plumbing defects caused by the introduction of foreign matter into the plumbing fixtures, electrical and mechanical systems, fire/life safety system, elevators, roof, paving, fire extinguishers and pest control, and whether capital or non-capital (collectively, and together with the janitorial services described in Clause 9(D) below, the **"Services"**). Upon request, LESSOR shall provide COUNTY with a complete copy of the janitorial and any other contracts for Services of an ongoing nature. Any repairs or replacements performed by LESSOR must be at least equal in quality and workmanship to the original work and be in accordance with all applicable laws. Such repair, maintenance and replacement shall be made promptly to keep the Premises and the Building in the condition described in this Clause 9. Should LESSOR default in its obligations under this clause, the COUNTY may exercise those remedies set forth in Clause 9(B) of this Lease.

2. **County Remedies**. If LESSOR fails to provide the Services within fifteen (15) days after SSA/Facilities Services Manager provides written notice thereof to LESSOR specifying any such default and affording LESSOR such fifteen (15) day period to complete the cure of such default, provided, however, that if the cure cannot reasonably be completed within such time period, LESSOR shall be afforded an additional reasonable amount of time to complete the cure, as long as LESSOR commences the cure within such time period and diligently pursues same to completion, without limiting any available remedy to COUNTY, COUNTY may, upon written notice to LESSOR and LESSOR's lender, to the extent contact information for such lender has been provided in writing to COUNTY, and, at its sole discretion, perform or arrange for the performance of such Services, and deduct the cost thereof plus and administrative charge of ten percent (10%) of the cost from any Monthly Rent payable without further notice. Additionally, in the event that LESSOR fails to provide required Services to the Premises sixty (60) days after the 15-day written notice, above, to LESSOR, LESSOR shall be obligated to pay a penalty to COUNTY of Twenty Five Dollars ($25) per day until such Services are provided by LESSOR.

3. **Warranties**. LESSOR shall initiate at purchase, and keep in force, all manufacturers' warranties including extended warranties for all building equipment. When manufacturer's warranties for the HVAC, roof and elevator expire, LESSOR will contract with an industry standard maintenance company (**"Vendor"**) that specializes in the maintenance of such equipment (and for the roof) for regular and scheduled inspections as recommended by the manufacturer, and immediately authorize said Vendor to perform any and all recommended maintenance to the equipment upon receipt of any inspection report. LESSOR shall authorize Vendors to provide COUNTY with copies of said reports upon COUNTY request. Should LESSOR fail to comply with the provisions of this clause, COUNTY may exercise those remedies set forth in Clause 9(B).

4. **Janitorial Services**. Janitorial supplies and services shall be provided to the Premises consistent with the past practices of LESSOR at the Premises during COUNTY's tenancy on a five (5) day- per-week basis in accordance with Exhibit D (JANITORIAL SPECIFICATIONS). In addition, upon request of COUNTY, LESSOR agrees to provide a copy of the contract with janitorial services as described in Exhibit D, to COUNTY. LESSOR understands that these services are a material consideration of this Lease to COUNTY. Should LESSOR fail to comply with the provisions of this Clause, COUNTY may exercise those remedies set forth in Clause 9(B).

5. **Code Compliance**. LESSOR shall be 100% responsible throughout the Term for any cost in the Premises, including all parking facilities, walkways, entrances, hallways and other public spaces, restrooms, and other devices or pathways for ingress and egress to the Premises regardless of cause with all the requirements of the Americans with Disabilities Act ("**ADA**") and all regulations issued by the U. S. Attorney General or other agencies under the authorization of the ADA, California Building Code, Title 24, Seismic Code, Fire and Life Safety requirements and, if applicable, California Green Building Standard Code. However, LESSOR shall not be responsible for any ADA violations resulting from alterations made by COUNTY or the placement of COUNTY's furniture, fixtures or equipment by COUNTY. LESSOR agrees to reimburse and indemnify, and defend COUNTY for any expenses incurred because of the failure of the Premises to conform with the above cited law and regulations, including the costs of making any alterations, renovations, or accommodations required by the ADA, or any governmental enforcement agency, or any court, any and all fines, civil penalties, and damages awarded against COUNTY resulting from a violation or violations of the above-cited law and regulations, and all reasonable legal expenses incurred in defending claims made under the above-cited law and regulations, including reasonable attorneys' fees. Should LESSOR fail to comply with the provisions of this Clause, the COUNTY may exercise those remedies set forth in Clause 9(B).

6. **HVAC System**. Air conditioning will be supplied to cause the temperature in Premises at a temperature consistent with other office buildings in Orange County, California, which are typically not less than **73**° F nor greater than °**75** F, during all COUNTY Working Hours.

Said temperature requirements shall be maintained during COUNTY's normal business operating hours (**"COUNTY Working Hours"**) which are:

Hours of Operation	Days of Operation
8:00 a.m. to 6:00 p.m.	Monday through Friday

Except for COUNTY Holidays, which holidays shall be provided to LESSOR on a yearly basis upon request to COUNTY. Some additional overtime hours may be used from time-to-time on any day, including Sundays, but said overtime hours shall be restricted to a timer or other limiting measures agreed to by LESSOR and COUNTY.

Notwithstanding the utilities provided during COUNTY Working Hours, LESSOR shall provide HVAC services prior to the beginning of COUNTY Working Hours in order for the temperature parameters required by this Lease, above, to be met and maintained at the beginning and throughout COUNTY Working Hours. There shall be no extra utility charges for HVAC services prior to the beginning of COUNTY Working Hours.

In order for the COUNTY to comply with the California Code of Regulations, Title 8, Section 5142 (**"Regulation 5142"**), and as it may be subsequently amended, LESSOR shall regularly inspect and maintain the HVAC system as required by Regulation 5142 and provide repair and maintenance accordingly. Inspections and maintenance of the HVAC system shall be documented in writing and LESSOR shall retain such records for at least five (5) years. LESSOR shall make all HVAC records required by this section available to COUNTY for examination and copying, within forty-eight (48) hours of a written request. LESSOR acknowledges that COUNTY may be subject to fines and/or penalties for failure to provide said records to regulatory agencies within the given timeframes. Should COUNTY incur fines and/or penalties as a direct result of LESSOR's failure to provide said records to COUNTY in a timely manner and as set forth herein, LESSOR shall reimburse COUNTY for said fines and/or penalties within thirty (30) days upon written notice. Should LESSOR fail to reimburse COUNTY within thirty (30) days, COUNTY may deduct the amount of the fine and/or penalty from any Monthly Rent payable without further notice.

7. **Emergency Services.** If LESSOR or its representative cannot be contacted by COUNTY for emergency repairs, as determined by the COUNTY, and/or Services the same day any emergency repairs and/or Services are necessary to remedy the emergency condition or to prevent imminent danger to persons or property, or if LESSOR following such contact by COUNTY is unable or refuses to make the necessary emergency repairs or provide the necessary Services, COUNTY may at its option have the necessary repairs made and/or provide Services to remedy the emergency condition, and deduct the cost thereof, including labor, materials, and overhead from any Monthly Rent payable without further notice.

8. **County Misconduct**. In the event any damage to the Premises or any systems therein is caused as a result of the negligence or willful misconduct of COUNTY employees or contractors, repairs are to be made by LESSOR, but the cost of such repairs shall be reimbursed by COUNTY, together with an administrative fee of five percent (5%) of such cost, within sixty (60) days from receipt of an invoice by LESSOR detailing materials and labor and paid in accordance with Clause 5 (RENT).

A. **Operations Shutdown.**

B. Should COUNTY be forced to completely shut down its operations within the Premises due to LESSOR's failure to provide Services required by this Clause 9 for a period of three (3) consecutive days, excluding weekends and holidays, and subject to the provisions of Section 4 of the General Conditions to this Lease, LESSOR shall be obligated to pay a penalty to COUNTY of Two Hundred Dollars ($200) per day. Should LESSOR's obligation to pay a penalty arise as a result of a shut down due to LESSOR's failure to provide said Services as set forth herein, LESSOR shall pay COUNTY within thirty (30) days of written notice. Should LESSOR fail to pay COUNTY within thirty (30) days, COUNTY may deduct the amount of the penalty from any Monthly Rent payable without further notice."

~~**9. REPAIR, MAINTENANCE, AND JANITORIAL SERVICES** (5.1 N)~~

~~LESSOR shall keep, maintain, and repair the building and other improvements upon the Premises in good and sanitary order and condition (except as otherwise provided in this Lease) including without limitation, the maintenance and repair of the roof, parking lot, sidewalks, common area restrooms including janitorial supplies and services, landscaping, store front, doors, window casements, glazing, plumbing, pipes, electrical wiring, and conduits, and the heating and air conditioning system including the maintenance of a service contract with a heating and air conditioning contractor, as necessary to maintain the property in which the Premises is located in good and sanitary order, condition, and repair. COUNTY shall reimburse LESSOR for the County's pro rata share of said expenses in accordance with Section 6 of the Lease. Notwithstanding the language in the paragraph above, COUNTY shall provide at its own cost and expense all repair and maintenance and services to the interior of the Premises.~~

~~A. Heating, Ventilation and Air Conditioning System (HVAC)~~

~~During all operating hours the HVAC system serving the Premises, to be repaired and maintained by the LESSOR, shall be capable of maintaining the Premises at 78º Dry Bulb at a maximum range of 40% to 60% Relative humidity during the summer when the outdoor temperature is 95º Dry Bulb, and at 68º Dry Bulb in the winter when the outside temperature is 35º Dry Bulb.~~

~~In order for the COUNTY to comply with the California Code of Regulations, Title 8, Section 5142, and as it may be subsequently amended, LESSOR shall inspect the HVAC system at least once~~

annually or on a schedule agreed to in writing by LESSOR and COUNTY, and provide repair and maintenance accordingly. LESSOR's inspections and maintenance of the HVAC system shall be documented in writing. The LESSOR shall at a minimum, maintain a record of: (a) the name of the individual(s) inspecting and/or maintaining the system, (b) the date of the inspection and/or maintenance, and (c) the specific findings and actions taken. The LESSOR shall ensure that such records are retained for at least five (5) years. The LESSOR shall make all HVAC records required by this section available to COUNTY for examination and copying, within forty-eight (48) hours of a written request from COUNTY. LESSOR acknowledges that COUNTY may be subject to fines and/or penalties for failure to provide said records to regulatory agencies within the given timeframes. Should COUNTY incur fines and/or penalties as a direct result of LESSOR's failure to provide said records to COUNTY, LESSOR shall reimburse COUNTY for said fines and/or penalties within thirty (30) days upon written notice. Should LESSOR fail to reimburse COUNTY within thirty (30) days, COUNTY may deduct the amount of the fine and/or penalty from any rent payable.

B. Janitorial Supplies and Services

LESSOR shall provide janitorial supplies and services on a five day per week basis (Monday through Friday) to the common areas and common area restrooms in accordance with Exhibit D (JANITORIAL SPECIFICATIONS) attached hereto and by reference made a part hereof.

If LESSOR fails to provide satisfactory janitorial supplies to Premises, the Chief Real Estate Officer, or designee may notify LESSOR either verbally or in writing; and if LESSOR does not provide janitorial supplies within twenty-four (24) hours after LESSOR has received such written notice from COUNTY, COUNTY may provide the janitorial supplies necessary or have others do so, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

If LESSOR or its representative cannot be contacted by COUNTY for emergency repairs and/or services the same day any emergency repairs and/or services are necessary to remedy the emergency condition, or if LESSOR following such contact by COUNTY is unable or refuses to make the necessary repairs within a reasonable time or provide the necessary services, as determined by the Chief Real Estate Officer, COUNTY may at its option have the necessary repairs made and/or provide services to remedy the emergency condition, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

10. ELECTRIC UTILITIES (5.2 N)

COUNTY shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the interior of the Premises directly to the utility company.

LESSOR shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the exterior of the Premises and to the common areas of the property in which the Premises is located.

INSURANCE (5.3 S)

Commercial Property Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial property insurance with all risk or special form coverage, covering the loss or damage to the Premises to the full insurable value of the improvements located on the Premises (including the full value of all improvements and fixtures owned by LESSOR) at least in the amount of the full replacement cost thereof, and in no event less than the total amount required by any lender holding a security interest.

LESSOR agrees to and shall include in the policy or policies of commercial property insurance a standard waiver of the right of subrogation against COUNTY by the insurance company issuing said policy or policies. LESSOR shall provide COUNTY with a Certificate of Insurance as evidence of compliance with these requirements.

Commercial General Liability Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial general liability insurance covering all injuries occurring within the building and the Premises. The policy or policies evidencing such insurance shall provide the following:

a. Name COUNTY as an additional insured;
b. Shall be primary, and any insurance or self-insurance maintained by COUNTY shall be excess and non-contributing;
c. LESSOR shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the Lease, upon which the County may suspend or terminate this Lease.
d. Shall provide a limit of One Million Dollars ($1,000,000) per occurrence; and
e. The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It

is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings. Prior to the Commencement Date of this Lease and upon renewal of such policies, LESSOR shall submit to COUNTY a Certificate of Insurance and required endorsements as evidence that the foregoing policy or policies are in effect.

If LESSOR fails to procure and maintain the insurance required to be procured by LESSOR under this Lease, COUNTY may, but shall not be required to, order such insurance and deduct the cost thereof plus any COUNTY administrative charges from the rent thereafter payable.

11. INDEMNIFICATION (5.5 A S)

C. Clause 11. INDEMNIFICATION (5.5 A S) is hereby deleted in its entirety from the Lease and replaced with the following:

"**Clause 11. INDEMNIFICATION (5.5 A S)**

COUNTY shall defend, indemnify and save harmless LESSOR and the LESSOR Parties, from and against any and all claims, demands, losses, or liabilities of any kind or nature which LESSOR or the LESSOR Parties may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, or arising out of, the negligence or intentional misconduct of COUNTY or the COUNTY Parties, in connection with the occupancy and use of the Premises by COUNTY or the COUNTY Parties.

Likewise LESSOR shall defend, indemnify and save harmless COUNTY and COUNTY Parties from and against any and all claims, demands, losses, or liabilities of any kind or nature which COUNTY or the COUNTY Parties may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, or arising out of, the negligence or intentional misconduct of LESSOR or the LESSOR Parties, in connection with the maintenance or use of the Premises by LESSOR or the LESSOR Parties."~~LESSOR shall defend, indemnify and save harmless COUNTY and COUNTY Parties from and against any and all claims, demands, losses, or liabilities of any kind or nature which COUNTY or the COUNTY Parties may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, or arising out of, the negligence or intentional misconduct of LESSOR or the LESSOR Parties, in connection with the maintenance or use of the Premises by LESSOR or the LESSOR Parties.~~

12. TAXES AND ASSESSMENTS (5.6 N)

All taxes and assessments which become due and payable upon the Premises shall be the full responsibility of LESSOR, and LESSOR shall cause said taxes and assessments to be paid prior to the due date. COUNTY shall reimburse LESSOR for its proportionate share of Taxes and Assessments pursuant to Section 5 of this Lease.

13. BUILDING AND SAFETY REQUIREMENTS (5.7 S)

During the full term of this Lease, LESSOR, at LESSOR's sole cost, agrees to maintain the Premises in compliance with all applicable laws, rules, regulations, building codes, statutes, and orders as they are applicable on the date of this Lease, and as they may be subsequently amended.

Included in this provision is compliance with the Americans with Disabilities Act ("**ADA**") and all other federal, state, and local codes, statutes, and orders relating to disabled access as they are applicable on the dates of this Lease, and as they may be subsequently amended.

LESSOR further agrees to maintain the Premises as a "safe place of employment," as defined in the California Occupational Safety and Health Act (California Labor Code, Division 5, Part 1, Chapter 3, beginning with Section 6400) and the Federal Occupational Safety and Health Act, where the provisions of such Act exceed, or supersede, the California Act, as the provisions of such Act are applicable on the date of this Lease, and as they may be subsequently amended.

In the event LESSOR neglects, fails, or refuses to maintain said Premises as aforesaid, COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY's sole option, cure any such default by performance of any act, including payment of money, and subtract the cost thereof plus reasonable administrative costs from the rent.

14. TOXIC MATERIALS (5.9 S)

COUNTY hereby warrants and represents that COUNTY will comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive

matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "**Toxic Materials**"). COUNTY shall be responsible for and shall defend, indemnify and hold LESSOR, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the storage, use, and disposal of Toxic Materials on the Premises by COUNTY. If the storage, use, and disposal of Toxic Materials on the Premises by COUNTY results in contamination or deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, COUNTY shall promptly take any and all action necessary to clean up such contamination.

Likewise, LESSOR hereby warrants and represents that LESSOR has in the past and will hereafter comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "Toxic Materials"). LESSOR shall be responsible for and shall defend, indemnify and hold COUNTY, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the previous, current and future storage, use and disposal of Toxic Materials on the Premises (or building if the Premises comprises only a portion of said building) by LESSOR. If the previous, current and future storage, use, and disposal of Toxic Materials on the Premises by LESSOR results in contamination or deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, LESSOR shall promptly take any and all action necessary to clean up such contamination.

15. SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE (6.4 S)

This Lease and all rights of the COUNTY hereunder are subject and subordinate to any mortgage or deed of trust which does now or may hereafter cover the Premises or any interest of LESSOR therein, and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions of any such mortgage or deed of trust; except, insofar as COUNTY is meeting its obligations under this Lease, any foreclosure of any mortgage or deed of trust shall not result in the termination of this Lease or the displacement of COUNTY.

In the event of transfer of title to the Premises, including any proceedings brought for foreclosure or in the event of the exercise of the power of sale under any mortgage or deed of trust or by any other transfer of title covering the Premises, COUNTY shall attorn to and recognize any subsequent title holder as the

LESSOR under all terms, covenants and conditions of this Lease. COUNTY's possession of the Premises shall not be disturbed by the LESSOR or its successors in interest, and this Lease shall remain in full force and effect. Said attornment shall be effective and self-operative immediately upon succession of the current title holder, or its successors in interest, to the interest of LESSOR under this Lease.

Notwithstanding the above, this Lease is contingent upon LESSOR's obtaining a Subordination, Attornment and Non-Disturbance Agreement from LESSOR's lender, within thirty (30) days of LESSOR's execution of this Lease. LESSOR shall require all future lenders on the Premises upon initiation of their interest in the Premises, to enter into a Subordination, Attornment and Non-Disturbance Agreement with COUNTY thereby insuring COUNTY of its leasehold interests in the Premises. Said Subordination, Attornment and Non-Disturbance Agreement shall be in the form of COUNTY's standard form Subordination, Attornment and Non-Disturbance Agreement shown on Exhibit E, attached hereto and by reference made a part hereof, or in a form approved by the Chief Real Estate Officer, and County Counsel.

Foreclosure shall not extinguish this Lease, and any lender or any third party purchasing the Premises at foreclosure sale shall do so subject to this Lease and shall thereafter perform all obligations and be responsible for all liabilities of the LESSOR under the terms of this Lease.

Upon default by LESSOR of any note or deed of trust, COUNTY may, at its option, make all lease payments directly to the lender, and same shall be applied to the payment of any and all delinquent or future installments due under such note or deed of trust.

16. ESTOPPEL CERTIFICATE (6.5 S)

COUNTY agrees that the County Executive Officer shall furnish from time to time upon receipt of a written request from LESSOR or the holder of any deed of trust or mortgage covering the Premises or any interest of LESSOR therein, COUNTY's standard form Estoppel Certificate containing information as to the current status of the Lease. The Estoppel Certificate shall be approved by the Chief Real Estate Officer, and County Counsel.

17. DEFAULTS AND REMEDIES (6.8 S)

The occurrence of any of the following shall constitute an event of default:

- Failure to pay any installment of any monetary amount due and payable hereunder;

- Failure to perform any obligation, agreement or covenant under this Lease.

In the event of any non-monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to initiate action to cure said breach.

In the event of any non-monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach and LESSOR shall have fifteen (15) days in which to initiate action to cure said breach.

In the event of any monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

In the event of any monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach, and LESSOR shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

18. DEBT LIMIT (6.9 S)

LESSOR acknowledges and agrees that the obligation of the COUNTY to pay rent under this Lease is contingent upon the availability of COUNTY funds which are appropriated or allocated by the COUNTY's Board of Supervisors for the payment of rent hereunder. In this regard, in the event that this Lease is terminated due to an uncured default of the COUNTY hereunder, LESSOR may declare all rent payments to the end of COUNTY's current fiscal year to be due, including any delinquent rent from prior budget years. In no event shall LESSOR be entitled to a remedy of acceleration of the total rent payments due over the term of the Lease. The Parties acknowledge and agree that the limitations set forth above are required by Article 16, section 18, of the California Constitution. LESSOR acknowledges and agrees that said Article 16, section 18, of the California Constitution supersedes any law, rule, regulation or statute, which conflicts with the provisions of this paragraph. Notwithstanding the foregoing, LESSOR may have other rights or civil remedies to seek relief due to the COUNTY's default under the Lease. Such rights or remedies may include a right to continue the COUNTY's right of possession under the Lease and sue for the rent as it becomes past due.

19. LABOR CODE COMPLIANCE (6.10 S)

Attachment F

LESSOR acknowledges and agrees that all improvements or modifications required to be performed as a condition precedent to the commencement of the term of this Lease or any such future improvements or modifications performed by LESSOR at the request of COUNTY shall be governed by, and performed in accordance with, the provisions of Article 2 of Chapter 1, Part 7, Division 2 of the Labor Code of the State of California (Sections 1770, et seq.). These provisions are applicable to improvements or modifications costing more than $1,000.

Pursuant to the provisions of Section 1773 of the Labor Code of the State of California, the Orange County Board of Supervisors has obtained the general prevailing rate of per diem wages and the general prevailing rate for holiday and overtime work in the locality applicable to this Lease for each craft, classification, or type of workman needed to execute the aforesaid improvements or modifications from the Director of the State Department of Industrial Relations. Copies of said prevailing wage rates may be obtained from the State of California, Department of Industrial Relations, or the County Executive Officer.

LESSOR hereby agrees to pay or cause its contractors and/or subcontractors to pay said prevailing wage rates at all times for all improvements or modifications to be completed for COUNTY within the premises, and LESSOR herein agrees that LESSOR shall post, or cause to be posted, a copy of the most current, applicable prevailing wage rates at the site where the improvements or modifications are performed.

Prior to commencement of any improvements or modifications, LESSOR shall provide the County Executive Officer with the applicable certified payroll records for all workers that will be assigned to the improvements or modifications. Said payroll records shall contain, but not be limited to, the complete name, address, telephone number, social security number, job classification, and prevailing wage rate for each worker. LESSOR shall provide, the County Executive Officer bi-weekly updated, certified payroll records for all workers that include, but not be limited to, the weekly hours worked, prevailing hourly wage rates, and total wages paid.

If LESSOR neglects, fails, or refuses to provide said payroll records to the County Executive Officer, such occurrence shall constitute an event of default of this lease and COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY's sole option, COUNTY may deduct future rent payable to LESSOR by COUNTY as a penalty for such non-compliance of paying prevailing wage, which rent deduction would be COUNTY's estimate, in its sole discretion, or such prevailing wage rates not paid by LESSOR.

Except as expressly set forth in this Lease, nothing herein is intended to grant authority for LESSOR to perform improvements or modifications on space currently leased by COUNTY or for which COUNTY has entered into a lease or lease amendment.

Clause 20. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (6.12 S) is hereby deleted from the Lease.

~~**20. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (6.12 S)**~~

~~In order to comply with child support enforcement requirements of the County of Orange, within thirty (30) days after COUNTY's execution of this Lease agreement, LESSOR agrees to furnish the County Executive Officer, COUNTY's standard form, *Child Support Enforcement Certification Requirements*, which includes the following information:~~

~~A. In the case where LESSOR is doing business as an individual, LESSOR's name, date of birth, Social Security number, and residence address;~~

~~B. In the case where LESSOR is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;~~

~~C. A certification that the LESSOR has fully complied with all applicable federal and state reporting requirements regarding its employees; and~~

~~D. A certification that the LESSOR has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, and will continue to so comply.~~

~~Failure of LESSOR to timely submit the data and/or certifications required above or to comply with all federal and state reporting requirements for child support enforcement, or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, shall constitute a material breach of this Lease. Failure to cure such breach within sixty (60) calendar days of notice from the County Executive Officer shall constitute grounds for termination of this Lease.~~

~~Notwithstanding any other provisions of this Lease, LESSOR shall be given an opportunity to cure as follows:~~

~~A. A notice of any claimed failure to comply shall be given to LESSOR, in writing, by personal delivery, or facsimile transmission, from the County Executive Officer. The written notice shall state the specific data or certification required, the specific federal or state reporting requirements for child support enforcement that has not been complied with or the specific Wage and Earnings Assignment Order and Notice of Assignment that has not been complied with; and~~

~~B. LESSOR shall have sixty (60) days from the actual receipt of the written notice to cure the failure to comply specified in the notice, provided that LESSOR's performance to cure within sixty (60) days is not hindered, impaired or prevented by federal, state or local agencies. If the claimed failure as set forth in the written notice is failure to perform an act by a certain time, the failure of performance of said certain act by said certain time shall be deemed cured for purposes of this Lease if it is timely performed in accordance with the provisions of this paragraph.~~

~~It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders and will not be used for any other purpose.~~

~~21.~~20. RIGHT TO WORK AND MINIMUM WAGE LAWS (6.13 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LESSOR shall require its employees that directly or indirectly service the Premises or terms and conditions of this Lease, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LESSOR shall also require and verify that its contractors or any other persons servicing the Premises or terms and conditions of this Lease, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LESSOR shall pay no less than the greater of the Federal or California minimum wage to all its employees that directly or indirectly service the Premises, in any manner whatsoever. LESSOR shall require and verify that all its contractors or other persons servicing the Premises on behalf of the LESSOR also pay their employees no less than the greater of the Federal or California minimum wage.

LESSOR shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the Premises or terms and conditions of this Lease.

Notwithstanding the minimum wage requirements provided for in this clause, LESSOR, where applicable, shall comply with the prevailing wage and related requirements, as provided for in the Clause entitled LABOR CODE COMPLIANCE of this Lease.

~~22.~~21. AUTHORITY (N)

The Parties to this Lease represent and warrant that this Lease has been duly authorized and executed and constitutes the legally binding obligation of their respective organization or entity, enforceable in accordance with its terms.

Clause 23. NOTICES (8.1 S) is hereby deleted in its entirety from the Lease and replaced with the following:

~~23.~~22. NOTICES (8.1 S)

All notices given pursuant to this Lease shall be in writing (unless otherwise specified herein), addressed as set forth below or as either Party may hereafter designate by notice and shall be deemed delivered (a) upon personal delivery (which shall include delivery by a courier or overnight delivery service), or (b) delivery by e-mail transmission (provided that a copy of such notice is concurrently sent by one of the other methods of service) but only if sent during COUNTY Working Hours, or otherwise on the next business day, or (c) seventy-two (72) hours after deposit in the United States Mail.

TO: LESSOR

Charles Manh and Anh Manh
Manh Family Trust
8990 Westminster Blvd., Second Floor
Westminster, CA 92683
E-mail: CharlieManh@ Hotmail.com

TO: COUNTY

County of Orange
Social Services Agency
500 N. State College Boulevard, 6th Floor
Orange, CA 92868
Attn: Director, Administrative Services
Phone: (714) 541- 7712
E-mail: An.Tran@ssa.ocgov.com

With a copy to:

County Executive Office
333 W. Santa Ana Boulevard, 3rd Floor

Santa Ana, CA 92701
Attention: Chief Real Estate Officer
Phone: (714) 834-3046
E-mail: Scott.Mayer@ocgov.com"

~~All written notices pursuant to this Lease shall be addressed as set forth below or as either party may hereafter designate by written notice and shall be deemed delivered upon personal delivery, delivery by facsimile machine, or seventy-two (72) hours after deposit in the United States Mail.~~

~~TO: LESSOR~~
~~Charles H. Manh and Anh Manh~~
~~Manh Family Trust~~
~~8990 Westminster Blvd., Second Floor~~
~~Westminster, CA 92683~~

~~TO: COUNTY~~
~~County of Orange~~
~~333 Santa Ana Blvd., 3rd Floor~~
~~Santa Ana, CA 92701~~
~~Attention: Scott Mayer, Chief Real Estate Officer~~
~~Email: Scott.Mayer@ocgov.com~~
~~Phone: (714) 834-3046~~

~~24.~~23. ATTACHMENTS (8.2 S)

This Lease includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
   A. Description - Premises
   B. Plot Plan - Premises
   C. Plans and Specifications
   D. Janitorial Specifications
   E. Subordination, Attornment, and Non-Disturbance Agreement

25. MISCELLANEOUS (N)

COUNTY may remove and dispose, and in a manner best suited for such removal and disposition, of any item(s) of furniture ("**Furniture Items**") off the Premises, which is (are) personal property of the LESSOR, as COUNTY deems appropriate or is of no use for COUNTY. LESSOR hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of property

arising from, growing out of or in any way connected with or related to the removal and disposition of the Furniture Items except claims arising from the concurrent active negligence of COUNTY, its officers, agents, and employees.

D. Clause 26. OPTION TO EXTEND TERM (2.3 N) is hereby added to the Lease:

"Clause 26. OPTION TO EXTEND TERM (2.3 N)

COUNTY's Chief Real Estate Officer or designee, shall have the option to extend the term of this Lease for one (1) four (4) year period (**"Extension Period"**) beyond June 30, 2021, which shall be memorialized in an amendment to the Lease executed by the Chief Real Estate Officer, on the same terms and conditions of this Lease except for (a) the base rent ("**Extension Option Base Rent**"), which shall be negotiated at the time of the option as set forth below and shall not result in a base rent higher than fair market value at the time of the extension option, and (b) the base year for operating expenses, which will be reset to the calendar year prior to the year in which the option is exercised. The Extension Period shall not contain an option for COUNTY to terminate the Lease during the term of the Extension Period. COUNTY shall give to LESSOR written notice of its intent to exercise its option to extend the term of this Lease for one (1) four (4) year period no sooner than twelve (12) months or later than four (4) months prior to the Lease termination date.

Subject to other provisions contained in this Lease, COUNTY shall accept the Premises during the Extension Period in the Premises' "as-is, where-is" condition. The Extension Option Base Rent shall be defined as Fair Market Rental Rate, defined and determined as set forth below in this Clause.

Following COUNTY's notice to LESSOR of its intent to extend the Lease for the Extension Period, COUNTY and LESSOR shall work in good faith and with commercially diligent and good faith efforts for sixty (60) days (the **"Initial Negotiation Period"**) in an effort to agree upon the Fair Market Rental Rate. When the Parties agree that negotiations are concluded, or by the expiration of the Initial Negotiation Period, LESSOR will provide COUNTY written notification of either the agreed upon Fair Market Rental Rate or LESSOR's last best offer (the **"Last Best Offer"**).

In the event that within or at the expiration of the Initial Negotiation Period COUNTY and LESSOR cannot agree upon the Fair Market Rental Rate, COUNTY and LESSOR by the end of the following thirty (30) days (the "**Second Negotiation Period**") shall attempt to determine the Fair Market Rental Rate by surveying and compiling rents for Class A office building properties similar in character, condition and quality to the subject property and located within a five (5) mile radius of the Building (**"Qualified Buildings"**), using industry standard sources and databases which contain lease information, lease comps, building specifications and space availabilities. The "**Fair Market Rental Rate**" shall be determined as follows: LESSOR and COUNTY shall independently survey Qualified Buildings that (i) contain at least 5,000 rentable square feet; (ii) offer a similar quantity of parking as the subject property; (iii) are otherwise similar in quality and function as the subject property; and (iv)

which have either entered into an arms-length transaction with an unaffiliated tenant of at least 2,000 rentable square feet within the past twelve (12) months or which have at least 5,000 rentable square feet of space available for lease (collectively, the "**Criteria**"). LESSOR and COUNTY shall each submit a list of up to five (5) Qualified Buildings. The two lists shall be consolidated into one master list. In the event of a discrepancy involving the same Qualified Building, COUNTY and LESSOR shall use best efforts to reconcile the difference. If either the highest or lowest quoted rates deviate by more than ten percent (10%) from the next closest rate, that building will be eliminated from the final master list (**"Final Master List"**). The per square foot rental rate ("**Rental Rate**") from each building shall be the monthly full service gross base rent per rentable square foot received or quoted by each Qualified Building, the Rental Rate shall exclude rent abatement concessions, but such Rental Rate shall include market tenant improvement allowances for renewing tenants, taking into account the cost to LESSOR to make periodic improvements to the Premises as provided in this Lease. The Rental Rate shall be compiled to the Final Master List and shall be summed and the summation divided by the number of Qualified Buildings (less any omitted Qualified Buildings) as follows:

Total Rental Rate of Considered Bldgs.÷ Number of Considered Bldgs. = Fair Market Rental Rate

The Extension Option Base Rent for the Option Period will be calculated as follows:

Extension Option Base Rent = Fair Market Rental Rate

In no event shall the Extension Option Base Rent for the Option Period be greater than LESSOR's Last Best Offer and the final determination will be binding on both Parties. There shall be no abatement of rent or Tenant Improvements, unless the Parties agree to such terms; the Extension Option Base Rent shall increase by three percent (3%) per annum during the Extension Period; and no other terms of the Lease shall change. COUNTY and LESSOR agree to then enter into a Lease amendment to consummate the transaction within a reasonable time period following determination of the Extension Option Base Rent, with time being of the essence."

E. The INSURANCE Clause is hereby deleted in its entirety from the Lease and replaced with the following:

"**27. INSURANCE**

Commercial Property Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial property insurance written on ISO form CP 00 10 10 12, or a substitute form providing coverage at least as broad, with all risk or special form coverage, covering the loss or damage to the Premises to the full insurable value of the improvements located on the Premises (including the full value of all improvements and fixtures

owned by LESSOR) at least in the amount of the full replacement cost thereof, and in no event less than the total amount required by any lender holding a security interest.

LESSOR agrees to and shall include in the policy or policies of commercial property insurance a standard waiver of the right of subrogation against the County of Orange, its elected and appointed officials, officers, agents and employees by the insurance company issuing said policy or policies. LESSOR shall provide the County of Orange with a Certificate of Insurance as evidence of compliance with these requirements.

Commercial General Liability Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial general liability insurance covering all injuries occurring within the building and the Premises. The policy or policies evidencing such insurance shall provide the following:

f. An Additional Insured endorsement using ISO form CG 20 26 04 13 or a from at least as broad naming the ***County of Orange, its elected and appointed officials, officers, agents and employees*** as an additional insured, or provide blanket coverage which will state, ***AS REQUIRED BY WRITTEN AGREEMENT***;
g. A primary and non-contributory endorsement using ISO form CG 20 01 04 13, or a form at least as broad evidencing that the Lessor's insurance is primary and any insurance or self-insurance maintained by the County of Orange shall be excess and non-contributing;
h. LESSOR shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the Lease, upon which the County may suspend or terminate this Lease.
i. Shall provide a limit of One Million Dollars ($1,000,000) per occurrence with a Two Million Dollars ($2,000,000) aggregate; and
j. The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings. Prior to the Commencement Date of this Lease and upon renewal of such policies, LESSOR shall submit to COUNTY a Certificate of Insurance and required endorsements as evidence that the foregoing policy or policies are in effect.

If LESSOR fails to procure and maintain the insurance required to be procured by LESSOR under this Lease, COUNTY may, but shall not be required to, order such insurance and deduct the cost thereof plus any COUNTY administrative charges from the rent thereafter payable.

Attachment F

F. Wherever a conflict in the terms or conditions of this Third Amendment and the Lease as previously amended by the First Amendment and Second Amendment exists, the terms and conditions of this Third Amendment shall prevail. In all other respects, the terms and conditions of the Lease, as previously amended and not specifically changed by this Third Amendment, shall remain in full force and effect.

//

IN WITNESS WHEREOF, the parties have executed this Lease the day and year first above written.

LESSOR

CHARLES H. MANH and ANH MANH,
Co-Trustees of the MANH FAMILY TRUST, dated August 15, 2006

By: _____ May ___, 2016
CHARLES H. MANH, Co-Trustee

By: _____ May ___, 2016
ANH MANH, Co-Trustee

APPROVED AS TO FORM:

OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By_____
Deputy County Counsel

RECOMMENDED FOR APPROVAL:

Social Service Agency

BY: _____
Carol Wiseman, Deputy Director

County Executive Office

~~**COUNTY**~~

~~COUNTY OF ORANGE~~
~~Chief Real Estate Officer~~

_____
~~By: Scott D. Mayer Per Ordinance No. 15-009 of the Board of Supervisors and Minute Order dated June 9, 2015~~

COUNTY

COUNTY OF ORANGE

Attachment F

BY: _____
Gail Dennis, Administrative Manager
Real Estate Services

_____
Chairwoman of the Board of Supervisors
Orange County, California

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRWOMAN OF THE BOARD PER GC § 25103, RESO. 79-1535

Attest:

_____
ROBIN STIELER
Clerk of the Board of Supervisors of
Orange County, California

GENERAL CONDITIONS (9.1-9.17 S)

1. LEASE ORGANIZATION (9.1 S)

The various headings in this Lease, the numbers thereof, and the organization of the Lease into separate sections and paragraphs are for purposes of convenience only and shall not be considered otherwise.

2. INSPECTION (9.2 N)

LESSOR or his authorized representative shall have the right at all reasonable times and upon reasonable advance notice to COUNTY, which authorization shall not be unreasonably withheld, to inspect the Premises to determine, if COUNTY is complying with all the provisions of this Lease.

3. SUCCESSORS IN INTEREST (9.3 S)

Unless otherwise provided in this Lease, the terms, covenants, and conditions contained herein shall apply to and bind the heirs, successors, executors, administrators, and assigns of all the parties hereto, all of whom shall be jointly and severally liable hereunder.

4. DESTRUCTION OF OR DAMAGE TO PREMISES (9.4 S)

"Partial Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is less than 25% of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

"Total Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is 25% or more of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

In the event of a Partial Destruction of the Premises, LESSOR shall immediately pursue completion of all repairs necessary to restore the Premises to the condition which existed immediately prior to said Partial Destruction. Said restoration work (including any demolition required) shall be completed by LESSOR, at LESSOR's sole cost, within sixty (60) days of the occurrence of said Partial Destruction or within an extended time frame as may be authorized, in writing, by COUNTY. The Partial Destruction of the Premises shall in no way render this Lease and/or any option to purchase null and void; however, rent payable by COUNTY under the Lease shall be abated in proportion to the extent COUNTY's use and occupancy of the Premises is adversely affected by said Partial Destruction, demolition, or repair work

required thereby. Should LESSOR fail to complete necessary repairs, for any reason, within sixty (60) days, or other time frame as may be authorized by COUNTY, COUNTY may, at COUNTY's sole option, terminate the Lease or complete necessary repair work and deduct the cost thereof, including labor, materials, and overhead from any rent thereafter payable.

In the event of Total Destruction of the Premises or the Premises being legally declared unsafe or unfit for occupancy, this Lease and/or any option shall in no way be rendered null and void and LESSOR shall immediately instigate action to rebuild or make repairs, as necessary, to restore the Premises (including replacement of all tenant improvements) to the condition which existed immediately prior to the destruction. All rent payable by COUNTY shall be abated until complete restoration of the Premises is accepted by COUNTY. In the event LESSOR refuses to diligently pursue or is unable to restore the Premises to an occupiable condition (including replacement of all tenant improvements) within 180 days of the occurrence of said destruction or within an extended time frame as may be authorized, in writing, by COUNTY, COUNTY may, at COUNTY's sole option, terminate this Lease or complete the restoration and deduct the entire cost thereof, including labor, materials, and overhead from any rent payable thereafter.

Further, LESSOR, at COUNTY's request, shall provide a suitable, COUNTY-approved temporary facility ("**Facility**") for COUNTY's use during the restoration period for the Premises. The Facility may be leased, at market rate, under a short term lease, for which the COUNTY will reimburse LESSOR the cost thereof, on a monthly basis.

5. AMENDMENT (9.5 S)

This Lease sets forth the entire agreement between LESSOR and COUNTY and any modification must be in the form of a written amendment.

6. PARTIAL INVALIDITY (9.6 S)

If any term, covenant, condition, or provision of this Lease is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

7. CIRCUMSTANCES WHICH EXCUSE PERFORMANCE (9.7 S)

If either Party hereto shall be delayed or prevented from the performance of any act required hereunder by reason of acts of God, performance of such act shall be excused for the period of the delay; and the period for the performance of any such act shall be extended for a period equivalent to the period of such

delay. Financial inability shall not be considered a circumstance excusing performance under this Lease.

8. WAIVER OF RIGHTS (9.9 S)

The failure of LESSOR or COUNTY to insist upon strict performance of any of the terms, conditions, and covenants in this Lease shall not be deemed a waiver of any right or remedy that LESSOR or COUNTY may have, and shall not be deemed a waiver of any right or remedy for a subsequent breach or default of the terms, conditions, and covenants herein contained.

9. HOLDING OVER (9.10 S)

In the event COUNTY shall continue in possession of the Premises after the term of this Lease, such possession shall not be considered a renewal of this Lease but a tenancy from month to month and shall be governed by the conditions and covenants contained in this Lease.

10. HAZARDOUS MATERIALS (9.11 S)

LESSOR warrants that the Premises is free and clear of all hazardous materials or substances.

11. EARTHQUAKE SAFETY (9.12 N)

LESSOR is informed and believes that the Premises is not in violation of any applicable seismic safety regulations and building codes.

12. QUIET ENJOYMENT (9.13 S)

LESSOR agrees that, subject to the terms, covenants and conditions of this Lease, COUNTY may, upon observing and complying with all terms, covenants and conditions of this Lease, peaceably and quietly occupy the Premises.

13. WAIVER OF JURY TRIAL (9.15 S)

Each Party acknowledges that it is aware of and has had the advice of Counsel of its choice with respect to its rights to trial by jury, and each party, for itself and its successors and assigns, does hereby expressly and knowingly waive and release all such rights to trial by jury in any action, proceeding or counterclaim brought by any party hereto against the other (and/or against its officers, directors, employees, agents, or subsidiary or affiliated entities) on or with regard to any matters whatsoever arising out of or in any way

connected with this agreement and/or any claim of injury or damage.

14. GOVERNING LAW AND VENUE. (9.16 S)

This agreement has been negotiated and executed in the State of California and shall be governed by and construed under the laws of the State of California. In the event of any legal action to enforce or interpret this agreement, the sole and exclusive venue shall be a court of competent jurisdiction located in Orange County, California, and the parties hereto agree to and do hereby submit to the jurisdiction of such court, notwithstanding Code of Civil Procedure section 394.

15. TIME (9.17 S)

Time is of the essence of this Lease.

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EXHIBIT A

DESCRIPTION OF PREMISES (10.1 N)

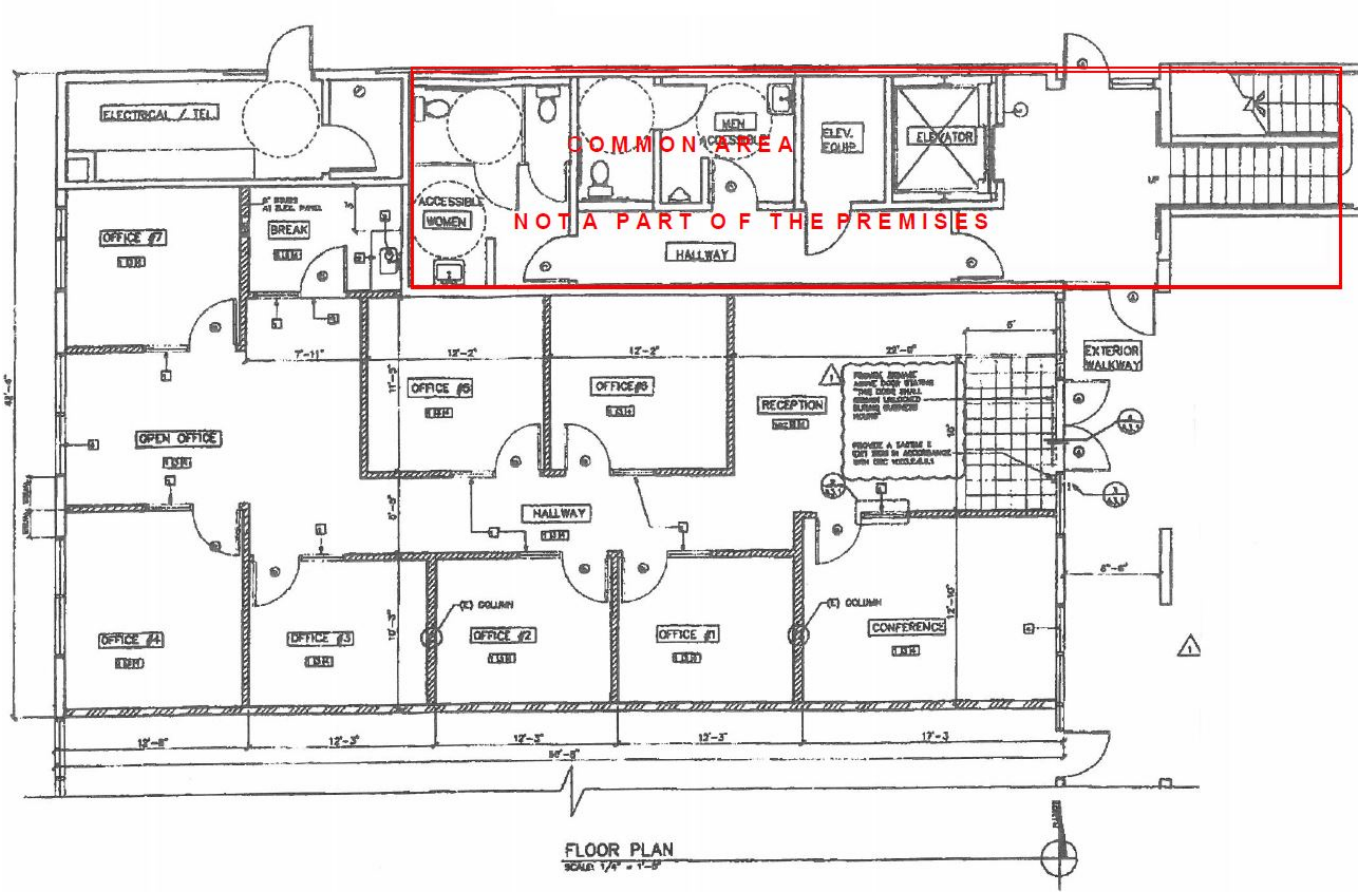
PROJECT: Community Customer Service Annex

All the Premises shown as the floor plan marked Exhibit B, attached hereto and made a part hereof, being a portion of the first floor of that certain two (2) story building located at 15496 Magnolia Street, Suite 111, in the City of Westminster, County of Orange, State of California, together with non-exclusive use of common area restrooms and thirteen (13) parking spaces in the parking areas shown on Exhibit B.

NOT TO BE RECORDED

EXHIBIT B
FLOOR PLAN OF PREMISES

15496 MAGNOLIA STREET, SUITE 111,
WESTMINSTER, CA



Gross Leasable Area: 2,120 Square Feet

EXHIBIT C

PERFORMANCE SPECIFICATIONS (10.3N) LESSOR shall perform the following Work prior to the Commencement Date of this Lease and according to the Tenant Improvement Performance Specifications that follow:

Specific locations to be identified by COUNTY prior to lease execution

1. Repair or replace door closer.
2. Replace stained ceiling tiles.
3. Repair or replace door closer.
4. Remove any signage from previous tenant that exists inside or outside of the Premises
5. Re-key front door and any internal door locks.
6. Provide the security code for existing alarm system.
7. Deliver the Premises with all electrical, plumbing and HVAC systems in proper working order.
8. Repair or replace any HVAC components resulting from findings of COUNTY's inspection of the HVAC system.

1. HEAT, VENT & AIR CONDITION ("HVAC")

A. Heating & air conditioning equipment shall have the capability of maintaining all occupied indoor areas at the room temperatures shown when outdoor temperatures are as follows:

OUTDOORS	*MAINTAIN INDOORS*
Summer – 95° Dry Bulb	78° Dry Bulb at a maximum range of 40% to 60% Relative humidity
Winter – 35° Dry Bulb	68° Dry Bulb

B. All HVAC controls pertinent to the Premises are to be located within the Premises.

C. All HVAC thermostats shall be concealed by a clear plastic tamper proof lock box.

2. ELECTRICAL & COMMUNICATIONS

A. Provide and install fluorescent lighting at all interior spaces that meet code and provide the following minimum lighting intensities at desk level:

LOCATION	*MINIMUM FOOT CANDLES:*
General Offices/Utility Rooms	60
Public Areas	30
General Corridors	20
LOCATION	*MINIMUM FOOT CANDLES:*
Other interior areas	I.E.S. Recommended Levels
Parking Lot	1

B. All Lighting controls pertinent to the Premises shall be located within the Premises.

COMPLIANCE WITH AMERICANS WITH DISABILITIES ACT ("ADA")

LESSOR shall assure that the Premises and Property are in compliance with current standards of the Americans with Disabilities Act for ingress and egress to the Premises and Property.

Attachment F

EXHIBIT D

JANITORIALSPECIFICATIONS (10.4 N)

It is the intent of this Exhibit to provide general guidelines for minimum janitorial service. Any absence of a specific janitorial service from this Exhibit does not relieve LESSOR of the obligation to provide such service should it become necessary.

Janitorial service as required in the clause entitled (REPAIR, MAINTENANCE AND JANITORIAL SERVICE) of this Lease, shall be inclusive of, but not limited to, the services as detailed below:

RESTROOMS

A. **NIGHTLY**:

1. Clean and damp-mop floors;
2. Wash all mirrors, bright work and enameled surfaces;
3. Wash and sanitize all basins, bowls, urinals, and toilet seats;
4. Dust, clean, and wash where necessary, all partitions, tile walls, dispensers, and receptacles;
5. Empty and sanitize all receptacles and sanitary napkin disposals;
6. Provide materials and fill all toilet tissue, towel, seat cover, sanitary napkin, and soap dispensers.

B. **MONTHLY**:

1. Machine strip restroom floors and apply finish/sealer where applicable;
2. Wash all partitions, tile walls, and enamel surfaces;
3. Vacuum all louvers, vents, and dust light fixtures.

MISCELLANEOUS SERVICES

1. Maintain building common/shared areas, corridors, and other public areas in a clean condition;
2. Surface parking lot is to be cleaned on a monthly or more frequent basis;
3. All interior and exterior windows of the building are to be cleaned quarterly.

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EXHIBIT E

SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT

THIS IS A SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT, made _____, 20__, by and between the County of Orange ("COUNTY") and _____ ("LENDER").

A. By lease dated _____, ("Lease"), _____ ("LESSOR") leased to COUNTY and COUNTY leased from LESSOR those certain Premises described as: _____.

B. LENDER is the holder or about to become the holder of a mortgage or Deed of Trust ("Note") which constitutes or will constitute a lien against the Premises leased by COUNTY pursuant to the aforesaid Lease.

C. LENDER has requested that _____ execute a Subordination, Attornment and Non-Disturbance Agreement in accordance with the terms of the Lease.

NOW, THEREFORE, the parties hereto do hereby agree as follows:

1. Subject to the terms and conditions of the Lease, all rights of COUNTY thereunder are or shall become subordinate to the Note and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions thereof.

2. In the event that LENDER succeeds to the interest of LESSOR under the Lease, by reason of foreclosure of the Note, by other proceedings brought to enforce any rights of LENDER under the Note, by deed in lieu of foreclosure, or by any other method, COUNTY shall promptly attorn to LENDER under all of the terms, covenants, and conditions of the Lease for the balance of the then-current term (and any extension or renewals thereof which may be effective in accordance with any option therefore contained in the Lease), with the same force and effect as if LENDER were the Lessor under the Lease. So long as COUNTY is not in default under the Lease, LENDER or its successors in interest shall not disturb the interests of COUNTY under said Lease, but shall allow said interests to continue in full force and effect for the balance of the then-current term and any extension available to COUNTY which may be provided in accordance with the Lease. Said attornment shall be effective and self-operative immediately upon LENDER'S succession to the interest of LESSOR under the Lease.

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3. This agreement may not be modified orally or in any manner other than by written agreement signed by the parties hereto or their respective successors or assigns. All of the terms, covenants, and conditions herein shall run with the land and shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

COUNTY:

COUNTY OF ORANGE

By:_____

County Chief Real Estate Officer

LENDER:

By:

Print Name:_____

Title:

APPROVAL AS TO FORM:
OFFICE OF THE COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By:_____

Deputy County Counsel

Date:_____

Attachment F

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Consider Authorization of Contract with Legislative Tracking Services Vendor and Proposed Budget Reallocation of Fiscal Year 2020–21 Operating Budget Funds

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Actions

1. Authorize the Chief Executive Officer to enter into a one-year subscription agreement with Wavelength Automation Inc. (CapitolTrack) for legislative tracking services in an amount not to exceed $2,500 during the 2020-21 fiscal year; and
2. Authorize the reallocation of up to $2,500 in budgeted but unused travel funds from Medi-Cal: Other Operating Expenses to fund legislative tracking services through June 30, 2021.

Background

As part of management's ongoing efforts to keep the Board of Directors apprised of proposed and upcoming changes in the law, CalOptima's Government Affairs staff monitors and evaluates legislation that may impact CalOptima, its members and stakeholders. Currently, staff utilize the free legislative information systems operated by the United States Congress (federal tracking) and the California State Legislature (state tracking), which offer a limited number of features that lead to manual tracking of legislation and potentially missed legislative activity.

Because the majority of legislative impacts to CalOptima result from State actions, staff propose procuring a state-specific legislative tracking service, CapitolTrack, which will enhance staff efficiency by reducing the need for manual identification and review of bills. During the 2019–20 legislative sessions, for example, staff manually identified more than 180 bills in the State Legislature that had potential impact to CalOptima.

Discussion

To enhance current legislation tracking and monitoring activities, staff evaluated the scope and associated subscription costs of several legislative tracking services that offer targeted, automated bill identification and tracking. While most platforms offer various combinations of federal and multistate tracking services, staff proposes to procure the lowest cost, limited-scope service that will achieve the necessary CalOptima objective. As CalOptima only operates within one state jurisdiction, and because most proposed and enacted legislation with a direct impact on CalOptima is introduced in the State Legislature, staff recommends contracting with CapitolTrack, a California-specific legislative tracking service, and seeks authorization to reallocate funds in advance of the FY 2021–22 budget cycle, to secure a one-year CapitolTrack subscription to start during the beginning of the 2021–22 Regular Session of the State Legislature. This will enhance staff's ability to ensure that all legislative actions of interest to CalOptima are captured for appropriate vetting and advocacy efforts, as authorized by the Board.

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While the Board has delegated authority to the CEO to make budget allocation changes within certain parameters (i.e., movement of up to $100,000 in unexpended budget dollars from one Board-approved program, item, or activity to another within the same expense category), this delegation does not apply in this situation because the proposed reallocation is to an expense category not previously approved by the Board.

Staff recommends that the funds for legislative tracking services be reallocated from the Travel budget, which was approved by the Board on June 4, 2020, in the amount of $64,644. The Travel budget is used to support staff travel to and/or participation in conferences, meetings, vendor site visits, field staff visits, community events and provider office visits. However, due to the ongoing COVID-19 public health emergency, nonessential staff travel has been substantially reduced since March 2020 in accordance with federal, state and local public health guidance, leading to a balance of unused but budgeted Travel funds for FY 2020–21. As such, reallocating funds from the Travel budget is expected to have no impact to CalOptima operations. In advance of the FY 2021–22 budget cycle, staff will be re-evaluating the Travel budget to accommodate legislative tracking services as an ongoing expense with minimal impact to CalOptima operations.

Fiscal Impact

The fiscal impact for these recommended actions is budget neutral. Unspent budgeted funds from Medi-Cal: Other Operating Expenses approved in the CalOptima FY 2020–21 Operating Budget on June 4, 2020, will fund the total cost of up to $2,500 for this action. Management plans to include expenses for legislative tracking services in future operating budgets.

Rationale for Recommendation

Legislative tracking and analysis continue to be priorities for CalOptima given the level of activity on health care issues in the California State Legislature. CalOptima staff anticipates that several important issues will require attention, involvement, and advocacy in the coming year, and having access to a customizable tracking tool should facilitate these efforts.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
CapitolTrack	320 C Street	West Sacramento	CA	95605

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Consider Approval of Reimbursement for Necessary Business Expenditures Incurred by Employees on Temporary Telework Due to the Coronavirus (COVID-19) Pandemic

Contact

Brigette Gibb, Executive Director Human Resources, (714) 246-8405
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

1. Approve extension of reimbursement at a flat rate of $45 per month per temporary teleworker, continuing January 1, 2021 on a month-to-month basis through June 30, 2021 for necessary business expenditures incurred by regular full-time and part-time employees on temporary telework due to the COVID-19 pandemic;
2. Authorize the Chief Executive Officer to extend the flat rate reimbursement on a month-to-month basis from January 1, 2021 through June 30, 2021 for employees on temporary telework; and
3. Authorize unbudgeted expenditures of up to $201,150 from existing reserves to fund the reimbursement for necessary business expenses of employees on temporary telework for the period of January 1, 2021, through June 30, 2021.

Background

In response to the national emergency resulting from the COVID-19 pandemic and recommendations for social distancing for COVID-19 community mitigation strategies, beginning in late March 2020, state and local agencies began implementing stay-at-home orders to limit professional, social, and community gatherings outside of a list of "essential activities." In order to maintain continuity of essential services and business functions while complying with the social distancing guidelines and a safe work environment for employees, CalOptima management initiated a phased-in deployment of temporary telework for CalOptima staff whose job duties can be performed remotely.

As the circumstances favor the continuation of temporary telework to minimize the number of employees present in CalOptima buildings and to slow the spread of COVID-19 in our community, management believes a delayed and gradual return of employees from temporary telework will be the best option for the safety of CalOptima employees. The temporary telework program has continued since March 2020, and temporary telework is in alignment with regulatory recommendations and guidance by the Centers for Disease Control and Prevention (CDC), the Governor's Industry Guidance, CalOSHA, and the Orange County Health Care Agency (OCHCA) . Based on the current circumstances and applicable guidelines, management considered CalOptima's obligations under California Labor Code section 2802 to reimburse employees for reasonable expenses in direct consequence of the performance of their obligations for employees on temporary telework.

At its June 4, 2020 meeting, the Board took the following actions:

1. Approved reimbursement at a flat rate of $45 per month, commencing April 1, 2020 through June 30, 2020 for necessary business expenditures incurred by regular full-time and part-time employees

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on temporary telework in response to the public health emergency arising from the COVID-19 pandemic;
2. Authorized the Chief Executive Officer (CEO) to extend the flat rate reimbursement on a month-to-month basis thereafter through December 31, 2020 for employees on temporary telework;
3. Authorized unbudgeted expenditures of up to $114,750 from existing reserves to fund the reimbursement for necessary business expenses of employees on temporary telework for the period of April 1, 2020, through June 30, 2020; and
4. Authorized unbudgeted expenditures of up to $229,500 from existing reserves to fund the reimbursement of business expenses for employees on temporary telework, in the event the CEO authorized the extension of the flat reimbursement rate on a month-to-month basis for all or part of the period of July 1, 2020, through December 31, 2020.

Discussion

Temporary telework was not contemplated as part of CalOptima Policy GA. 8044: Telework Program, and approximately 53% of employees are currently on temporary telework, which is in addition to those employees who were already teleworking as part of CalOptima's Telework Program. As temporary telework has evolved from a voluntary program to one that is instrumental in CalOptima's efforts to mitigate the spread of the coronavirus, CalOptima, as an employer, has an obligation to pay for a "reasonable percentage" of necessary business expenses such as internet and cell phone service even if it does not require an employee to incur an extra cost.

While personal cell phone use is discouraged, management recognizes that during these unique circumstances, occasional use of a personal cell phone might be required on an occasional basis. Management also recognizes that internet costs are not generally covered as a business expense and most employees do not use the internet exclusively for CalOptima business. However, to ensure compliance with reimbursement requirements under the Labor Code during these unique circumstances, management is recommending that employees on temporary telework continue to be reimbursed for a reasonable percentage of these necessary business expenses.

Staff has determined that a flat reimbursement rate of forty-five dollars ($45) per month is a reasonable estimate of the proportional cost of cell phone, internet and other necessary business expenses. Management is requesting Board approval of the extension of the flat rate reimbursement for employees on temporary telework for the months of January 1, 2021 through June 30, 2021, for each month an employee is on temporary telework. Employees who believe they are entitled to additional reimbursement must submit an expense reimbursement request with supporting documentation showing why they believe they should receive additional reimbursement, which will be reviewed on a case-by-case basis.

Fiscal Impact

The recommended action to authorize expenditures to fund the monthly reimbursement for necessary business expenses of employees on temporary telework for the period of January 1, 2021, through June 30, 2021, is an unbudgeted item. Based on an estimated monthly average of 745 regular full-time and part time employees on temporary telework, a proposed allocation of up to $201,150 from existing reserves will fund this action.

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Funding for the extension of the flat reimbursement rate on a month-to-month basis was not included in the Fiscal Year 2020-21 Operating Budget approved by the Board at its June 2020 meeting.

Rationale for Recommendation
Continuing the flat reimbursement rate will ensure compliance with Labor Code section 2802 to provide reimbursement for necessary business expenses as a result of temporary telework and also avoid the administrative burden of evaluating individual requests and potentially making disparate determinations on the appropriate reimbursement amount(s) based on a reasonable percentage(s) for each expense item.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez — *01/27/2021*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
Silver Ho, Executive Director, Compliance, (657) 235-6997

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Medi-Cal Agreement between the California Department of Health Care Services and CalOptima related to rate changes.

Background

As a County Organized Health System (COHS), CalOptima contracts with the California Department of Health Care Services (DHCS) to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with the DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 49, which extends the agreement through December 31, 2021. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to ensure that the Medi-Cal members DHCS assigns to CalOptima have access to covered health care services.

Discussion

DHCS has informed Managed Care Plans (MCPs), including CalOptima, that it will submit three amendments to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate rate changes related to (1) Base Medi-Cal Classic rates, ACA Optional Expansion (OE) rates, Coordinated Care Initiative (CCI) Non-Full Dual rates, Hyde (Abortion) rates, Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, Managed Long–Term Services and Supports (MLTSS) add–on rates, Proposition 56 directed payments for the period of January 2021 through December 2021, (2) Calendar Year (CY) 2020 Coordinated Care Initiative (CCI) Full Dual Rate Ranges, and (3) CY 2021 CCI Full Dual Rate Ranges to MCP contracts.

Rate Changes

DHCS's three proposed amendments seek to incorporate rates related to:

- (1) Base Medi-Cal Classic, ACA Optional Expansion (OE) and Hyde (Abortion) Proposition 56 rates for the period of January 1, 2021 to December 31, 2021, with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, Hyde (Abortion) rates, Managed Long–Term Services and Supports (MLTSS) add–on rates, and Proposition 56 directed payments, (2) CCI Full Dual rates for the period of January 1, 2020 to December 31, 2020 and (3) CCI Full Dual rates for the period of January 1, 2021 to December 31, 2021.

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Package XX: CY 2021 Rates

Base Classic Medi–Cal and ACA Optional Expansion Rates
Noteworthy items for the updated rates for January 2020 to December 2021 include, but are not limited to:

- Additional base adjustments
- Population Acuity Adjustment
- Low Acuity Non-Emergent (LANE) Services Efficiency Adjustment
- Risk Adjustment
- MCO Tax
- Directed Payments/Pass-Through Payments
- Final Projected Enrollment
- COVID-19 Considerations
- Any other CMS approved policy changes/financing arrangements implemented or managed care adjustments

The base Medi–Cal Classic and ACA OE capitation rates for January 1, 2021 through December 31, 2021 were first sent to CalOptima as draft rates in September 2020 and as final rates in December 2020. The rates reflect a rate rebase that now utilizes CY 2018 experience, including health plan submitted Rate Development Templates (RDTs) and encounter data. The rebase also includes the following:

- Base Data Adjustments
- Long-Term Care (LTC) adjustment to reflect the 10% LTC facility increase for January 2021 through June 2021, aligning with the assumed Public Health Emergency (PHE) expiration in June 2021.
- An adjustment was derived to account for three new psychiatric codes for treatment of mental health or substance use condition by the treating physician or other qualified health professional for Psychiatric Collaborative Care (PCC) management services.
- Decrease in the average acuity level of the overall population.
- Final adjustment for Low Acuity Non-Emergent (LANE) events to the Emergency Room Category of Service.
- Final projected membership based on the assumption of the Public Health Emergency (PHE) ending in June 2021.
- Rate add-on for MCO Tax Per Member Per Month (PMPM) calculations.
- Updated Hospital Quality Assurance Fees (HQAF) for the CY 2021 rate year.
- COVID-19 rate add-on for projected CY 2021 liabilities for COVID-19 testing and treatment, and assumptions for the amount of deferred and cancelled care that will occur in CY 2021 due to the COVID-19 pandemic.
    - An additional 10% adjustment was applied to the Mental Health – Outpatient line to account for higher expected levels of mental health service utilization due to the effects of the pandemic.

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- Removal of costs associated with pharmacy services billed on a pharmacy claim due to the carve-out of the pharmacy benefit.
- Removal of Managed Long-Term Services and Supports (MLTSS) – related costs.
- Behavioral Health Treatment (BHT) services (not including the Comprehensive Diagnostic Evaluations) have been excluded from the base data as they are included within the BHT supplemental payment process.
- Mental Health (MH) carve-in projections for CY 2021 are reflected in the base data with plan-specific projections developed utilizing health plan reported experience from CY 2016 through CY 2018.
- ACA OE Dual Members – OE members with dual eligibility were reported in their prospectively appropriate category of aid (COA) group in the CY 2018 base data (SPD for OE partial duals and SPD/Full Dual for OE Full Duals). Where necessary, adjustments were made to bring ACA OE Full-Dual payment levels in line with those appropriate for the SPD/Full-Dual population.
- In Lieu of Services (ILOS) were removed from the base data experience.
- Global administrative adjustment assumed that administrative dollars were removed from the payments made by the direct health plan to the global health plan in the development of the base data.
- Costs for Whole Child Model (WCM) members were removed from the base data for COHS counties as they are now included in the separate WCM rates.
- Hospital Pricing Adjustments were made to adjust high hospital unit cost amounts as reported in the CY 2018 RDT.
- Incentive payment levels have been refined to more appropriate levels.
- Program changes were applied for the following:
    - Pediatric Palliative Care (PPC)
    - Diabetes Prevention Program (DPP)
    - Proposition 56 CBAS
    - Non-Medical Transportation (NMT)
    - Ground Emergency Medical Transportation (GEMT) increases
    - Optional Benefits (e.g. Vision, Podiatry, Speech Therapy)
    - Long-Term Care (LTC) and Hospice
    - Potentially Preventive Admissions (PPA) Efficiency Adjustments
    - Healthcare Common Procedure Coding System (HCPCS) Efficiency Adjustment
- Implementation of the maternity carve-out for the Child, Adult, and ACA OE COA groups with receipt of maternity supplemental payments effective January 1, 2021.
- Higher administrative load levels to account for the removal of pharmacy services.
- Inclusion of Potentially Preventable Admissions (PPA) adjustments by category of aid (COA).
- Reduction of 0.5% of the underwriting gain load compared to previous years which now reflect 1.5%, 2.5% and 3.5% at the lower bound, midpoint, and upper bound, respectively.
- Current projected enrollment the CY 2021 rating period.
- Whole Child Model (WCM) updates, including:
    - Utilization of a two-year base period (CY 2017 and CY 2018) that is a credibility-based blend of cost and utilization experience from Supplemental Data Requests (SDRs), Fee-For-Service (FFS) and encounter data.

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  - Adjustments to reflect the anticipated use of Spinraza part of which applies to the outpatient service category to reflect projected utilization assumed to be administered via Physician Administered Drugs (PADs) with the remainder assumed to be carved-out with the pharmacy benefit.
  - Acuity adjustment based on analysis of WCM costs in Q1- Q3 2019 Supplemental Data Request (SDR), encounter and risk score data.
  - Updates to WCM county allocation amounts for Medical Management and Care Navigation (MM/CN) to include final county split amounts for these services.
  - Revised administrative load assumptions to align closer with mainstream rate development.
  - The remaining updates were made consistent with mainstream rates:
    - Updated program changes
    - Updated projected enrollment
    - Inclusion of all add-on PMPMs
- The Capitation Rate Calculation Sheets (CRCS) display the category of service detail on the development of the rates from the base data to the gross medical expense (GME), accounting for trend, policy changes, and other adjustments.
- Individual adjustment items related to policy changes, efficiencies and other adjustments, including descriptions, categories of aid (COA) / Categories of Service (COS) impacted and the GME PMPM impact.
- The January through March 2021 portion of the CY 2021 rating period will include a pharmacy component due to lengthening the transition time to full implementation of Medi-Cal Rx to April 1, 2021. The rate add-on is consistent with all other categories of service with the following items of note:
  - The pharmacy add-on was developed assuming a 2% administration load.
  - The pharmacy add-on was developed with the lower bound underwriting gain load.
  - The pharmacy add-on is not risk adjusted,
  - MAC and Part B/D efficiency adjustments consistent with prior adjustments have been applied.
  - The population acuity adjustment has also been applied.
  - Hepatitis C supplemental payment rates will be in effect for January through March 2021.
  - The final pharmacy component of the CY 2021 rates and the hepatitis C supplemental payments will be specific to the applicable period (January through March 2021) and will be developed leveraging the CY 2018 base data.

Behavioral Health Treatment (BHT) Payments

BHT supplemental payment rates for the period of January 1, 2021 through December 31, 2021 were sent to CalOptima in September 2020. These final BHT rates contain the following updates:

- The CY 2021 rates used CY 2018 and CY 2019 as the base period including restated CY 2018 BHT data.
- The same cost relativity factor (non-ASD to ASD) used in the 18-month bridge period BHT rates was also used for the CY 2021 rates.

- Most other components of the BHT supplemental rate development methodology that were utilized for July 2019 through December 31, 2020 were maintained for CY 2021 including a 2-year base period, global member experience and credibility adjustment.

Abortion (Hyde) Payments and Proposition 56 Add–On

Abortion (Hyde) payments for the period of January 2021 through December 2021 were first sent to CalOptima as draft rates in September 2020 and final rates in December 2020. The Hyde rates contain one summary tab reflecting the rates by county and category of aid (COA).

Proposition 56 Directed Payments

CalOptima received draft Proposition 56–Physicians, Trauma, Developmental Screening, Family Planning, and Value Based Payment PMPM add-ons in October 2020 and final rates in December 2020.

Highlights regarding the Prop 56 physician directed payment amounts include the following:

- CY 2021 estimates were developed using a rate development methodology consistent with 2019-20 estimates.
- Utilization of CY 2018 reported RDT experience and 2018 encounters.
- Adjustments to the final amounts including offsets for Medicare Part B members.
- FQHC/RHC/CBRC/IHS utilization is not included as these providers are exempt from Prop 56.
- Projected member months for the first 6 months of the CY 2021 rating period by COA along with anticipated number of Prop 56 impacted services.
- Inclusion of combined E&M and preventive code utilization per 1,000 members and the resulting adjustment of PMPM add-on amounts.
- Inclusion of administrative and underwriting gain loads consistent with CY 2021 rate add-ons.

Highlights regarding the Prop 56 directed payments for Trauma, Developmental, Family Planning and Value Based Purchasing (VBP) include the following:

- Trauma, developmental screening, and VBP were developed using CY 2018 enrollment data with consistent actuarial assumptions as used for the corresponding 2019-20 Bridge Period add-ons.
- Add-ons are only applicable for the first 6-month of the contract year to align with the 6-month effective period of January 1, 2021 to June 30, 2021.
- Family planning add-on rates applicable for the full contract year were developed using CY 2018 enrollment and encounter data with consistent actuarial assumptions as used for the 2019-20 Bridge Period add-ons.
- Exclusion of Part B eligible members and services billed as pharmacy claims for all four initiatives.
- Exclusion of FQHC/RHC/CBRC/Indian Health Services (IHS) utilization from the final PMPM add-on amount for Family Planning and VBP as such services provided at these facilities are not eligible for Prop 56 payments.
- No changes have been made in CY 2021 compared to the 2019-20 Bridge Period amount to the eligibility criteria of services receiving a Prop. 56 payment nor to the Prop. 56 amounts.

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- Exhibits include utilization per 1,000 members, the unit cost and resulting PMPM add-on amounts.
- Final PMPM add-on amounts include administrative and underwriting gain loads consistent with the CY 2021 rate add-ons.

Health Homes Program (HHP) Rates

CalOptima received final HHP rates for January 2021 to December 2021 in October 2020. Highlights regarding these rates are as follows:

- Rates were divided into "Non- COVID-19" and "COVID-19" adjustments and includes the following:
    - Statewide premiums for Chronic Conditions (CC) Only and the Serious Mental Illness (SMI) HHP populations separately.
    - CalOptima-specific adjustments to the statewide rates and blend the CC Only and SMI rates together based on CalOptima's HHP enrollment projections.
    - COVID-19 adjustments.

- Non-COVID-19 adjustments are those that would have been applied absent any impact from the COVID-19 pandemic and include the following:
    - Existing Care Coordination (ECC) Carve-Out: CY 2018 RDT reporting in Schedule 1-U was leveraged for CY 2021 HHP rate development to inform the ECC carve-out.
    - CC/SMI member mix was updated using the most recent Targeted Engagement List (TEL).
    - Reduced housing navigator caseload assumptions from housing navigators in Tiers 2 and 3 to be equivalent to the caseload assumed in Tier 1.
    - Other updates to census information, provider type salary information, Complex Case Management (CCM)/Behavioral Health Integration (BHI) payment rates and regional factors, and cost-of-living information.

During the Public Health Emergency (PHE) due to COVID-19, similar to other healthcare operations, HHP's capacity to serve members decreased. As such, COVID-19 adjustments for the CY 20201 HHP rates were developed to account for the decrease in capacity. The most recent assumptions conclude that the PHE would affect HHP operations for 12 months (April 2020 through March 2021) and HHP operations would be limited to 50% capacity during this time. After the end of the 12 months (i.e. April 2021), it is assumed that health plans would be able to resume HHP operations at full capacity either as a result of the end of the pandemic or through adaptation.

- Therefore, COVID-19 adjustments to HHP rates include the following:
    - Increased assumed caseload for Community Health Workers (CHWs) due to more services being provided via telehealth.
    - Decreased member engagement capacity and rate of enrollment into the HHP due to assumed operations at 50% capacity during the 12-month period.
    - Increase in HHP rates due to higher acuity and level of care attributed to newer HHP members.

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- Engagement cost adjustments to spread over 18 months taking into account slower enrollment of members due to COVID-19.
- Slower member movement through tiers due to assumed operations at 50% capacity resulting in fewer services provided to HHP members.

Coordinated Care Initiative (CCI) Non–Full Dual and Partial–Dual Rate Ranges

CalOptima received CCI non-full dual draft rates for January 2021 to December 2021 in September 2020 and final rates in December 2020. Highlights regarding these final rates are as follows:

- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) and pediatric nursing facilities were removed from the LTC program change calculation.
- Adjustments were applied to the CCI Non-Dual MLTSS rates to account the 25% rate increase for the Multipurpose Senior Service Program (MSSP).
- Updates to administrative load assumptions due to the removal of pharmacy services from the capitation rates along with a 0.25% lowering of the underwriting gain assumption.
- Development of the Home and Community-Based Services (HCBS) inclusive of In-Home Supportive Services (IHSS) severely impaired utilizer months.
- LTC 10% increase for assumed duration of PHE and Psychiatric Collaborative Services.

Package XX: CY 2020 CCI Full Dual Rates

CY 2020 CCI Full Dual Rates

CalOptima received CY 2020 CCI full dual draft rates in August 2020 and updated draft rates in September 2020. Highlights regarding these rates are as follows:

- The rates reflect a rate update from the CY 2019 CCI Full Dual rates that continues to utilize CY 2017 base data experience including plan submitted RDTs and encounter data.
- LTC rate increases including the application of the standard LTC adjustment that takes annual LTC rate changes into account and application of a 10% LTC unit cost increase effective March 1, 2020 pursuant to the Public Health Emergency (PHE) and State Plan Amendment (SPA) 20-0024.
- Hospice rate increases
- Development of Non-Medical Transportation (NMT) amounts using submitted NMT supplemental data request (SDR) information.
- Ground Emergency Medical Transportation (GEMT) add-on
- Restoration of 10% rate reduction previously applied to non-exempt CBAS facilities.
- MSSP rate increase
- Optional benefits restoration

Package XX: CY 2021 CCI Full Dual Rates

CY 2021 CCI Full Dual Rates

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CalOptima received the CY 2021CCI full dual draft rates in November 2020 and final rates in December 2020. Highlights regarding these rates are as follows:

- Rebasing of the rates that now utilize CY 2018 experience including health plan submitted RDTs and encounter data.
- Removal of In Lieu of Services (ILOS) from the base data experience.
- Removal of assumed administrative dollars from the payments made to the global health plan.
- LTC 10% rate increase for January through June 2021, aligning with the assumed PHE expiration in June 202.
- Final projected membership based on the assumption of the Public Health Emergency (PHE) ending in June 2021
- Hospice rate increases
- Development of pharmacy rate add-on for the first quarter of 2021 due to implementation of the pharmacy carve – out on April 1, 2021 developed assuming a 2% administration load.
- Modeling was performed to project CY 2021 liabilities by COA and county for COVID-19 testing and treatment, assumptions for the amount of deferred and cancelled care expected to occur in CY 2021 due to the COVID-19 pandemic, and higher expected levels of mental health service utilization due to the effects of the pandemic.
    - The net impact of COVID-19 on the Dual population was negligible; as such, $0.00 PMPMs are reflected within the rates for the COVID-19 add-on.
- Rate add-on for MCO Tax PMPM calculations.
- NMT amounts were developed using the health plan submitted NMT supplemental data request (SDR) information
- GEMT add-on resulting in a per trip rate increase for GEMT service providers.
- Restoration of the 10% rate reduction previously applied to non-exempt CBAS facilities
- 25% reimbursement rate increase for MSSP services
- Restoration of adult optional benefits including vision, audiology, speech therapy, incontinence creams and washes, and podiatry.
- Reduction of underwriting gain load compared to CY 2020 rates.
- Current enrollment is based on DHCS' estimate of enrollment for the CY 2021 rating period.
- CRCS display the county-specific category of service detail on the development of the base rates by Category of Aid (COA) from the finalized base data through to the gross medical expense, accounting for trend, policy changes, and managed care/efficiency adjustments.
- CMC capitation rates summary displays the county-wide base member months and the total payment for each COA, inclusive of administrative and underwriting gain loads as detailed in the CRCS.
- Non-CMC capitation rates summary displays information for the (1) Eligible But Not Enrolled (EBNE) population, (2) CMC Ineligible population and (3) EBNE and CMC Ineligible combined.

The anticipated impact of these proposed rate changes is identified in the Fiscal Impact section.

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Fiscal Impact

CY 2021 Medi-Cal Base Rates

Medi-Cal Classic and Medi-Cal Expansion
When comparing CY 2021 rates to the Bridge Period (i.e., July 1, 2019, through December 30, 2020) rates net of pharmacy, the updated rates are 6.4% or $11.93 PMPM higher for Medi-Cal Classic, and 2.3% or $7.83 PMPM lower for Medi-Cal Expansion. However, most of the changes to rates were anticipated and included in the CalOptima Fiscal Year (FY) 2020-21 Medi-Cal Operating Budget. HHP, WCM and COVID-19 adjustments for January 1, 2021, through June 30, 2021, were authorized and passed through to providers through a separate Board action on January 7, 2021. In aggregate, Staff projects the net fiscal impact to CalOptima will be slightly more favorable than the CalOptima FY 2020-21 Medi-Cal Operating Budget assumptions approved by the Board on June 4, 2020.

Staff will incorporate the CY 2021 Medi-Cal rates for the period of July 1, 2021, through December 31, 2021, in the FY 2021-22 Operating Budget.

BHT, Hepatitis C, Abortion (Hyde), MLTSS, Proposition 56 add-on rates
The capitation rates for January 1, 2021, through December 31, 2021, that includes updates for BHT and Hepatitis C supplemental payments, Abortion (Hyde) payments and Proposition 56 add-on, and MLTSS add-on rates are projected to be revenue neutral to CalOptima for FY 2020-21. Staff will incorporate the rate adjustments in the CalOptima FY 2021-22 Medi-Cal Operating Budget.

CY 2020 CCI Full Dual Eligible Rates
For CY 2020, there is no additional fiscal impact to CalOptima. Given the timing of CalOptima's receipt of the rate adjustments, Staff has included the updated rates for the period of January 1, 2020, through June 30, 2020, in the applicable annual financial statement for FY 2019-20.

CY 2021 CCI Full Dual Eligible Rates
Compared to CY 2020 CCI full dual eligible rates, the CY 2021 rates are approximately 7.7% or $39.24 PMPM lower. In aggregate, Staff projects the net fiscal impact for the period January 1, 2021, through June 30, 2021, to CalOptima will be slightly more favorable than the CalOptima FY 2020-21 Operating Budget assumptions approved by the Board on June 4, 2020. Staff will incorporate the CY 2021 CCI full dual eligible rates for the period of July 1, 2021, through December 31, 2021, in the FY 2021-22 Operating Budget.

Rationale for Recommendation
DHCS develops capitation rates according to base data reported by CalOptima through the Rate Development Template (RDT) process and adjusted for trends and program changes. Execution of the contract amendment will ensure revenues, expenses and cash payment are consistent with the approved budget to support CalOptima operations.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Appendix summary of amendments to Primary Agreements with DHCS

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 9

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Bridge Period Contract Amendment

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
Silver Ho, Executive Director, Compliance, (657) 235-6997

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between DHCS and CalOptima related to the Bridge Period Contract Amendment for July 1, 2019 to December 31, 2020

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with the California Department of Health Care Services (DHCS). Amendments to this agreement are summarized in the attached appendix, including Amendment 49, which extends the agreement through December 31, 2021. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

Bridge Period Contract Amendment (July 1, 2019 to December 31, 2020)

On November 18, 2020, DHCS provided managed care plans (MCPs) with an updated draft Bridge Period contract amendment, and notified MCPs that they will submit this amendment to the Centers for Medicare & Medicaid Services (CMS) on December 30, 2020.

This contract amendment contains notable language changes, and it is worth noting that DHCS has generally already implemented the requirements of the Bridge Period contract amendment by issuing sub-regulatory guidance such as All Plan Letters (APLs). Simultaneously, DHCS has been working with CMS to formalize the requirements in DHCS's contracts with MCPs, including CalOptima. DHCS's implementation of these requirements via sub-regulatory guidance prior to the formal inclusion of the requirements in MCP contracts is largely due to the lengthy CMS review process. While the contractual obligations are retroactive, CalOptima staff has implemented the required operational changes and other contractual requirements by following the DHCS APL guidance

The amendment does not contain any rate changes or otherwise set any rates. DHCS has only shared a boilerplate contract amendment with CalOptima at this time and has noted that certain provisions of the boilerplate will be absent in the MCP-specific amendments that are ultimately provided for signature, as appropriate. For example, the boilerplate amendment provided contains provisions related to the

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Independent Medical Review (IMR) process that is only applicable to MCPs with Knox-Keene Licensed Medi-Cal products. DHCS has assured CalOptima staff that these provisions will be struck from CalOptima's amendment. If the final contract amendment is not consistent with staff's understanding as presented in this document, or if it includes substantive and unexpected language changes, staff will return to the Board of Directors for further consideration.

What follows is a description of the changes contained within the Bridge Period amendment, sorted by category:

Category	Requirement	Sub-Regulatory Guidance
Quality Improvement System	-Include methods to ensure members are able to obtain appointments within established standards for time and distance, timely access and alternative access.	DHCS All-Plan Letter (APL) 20-003: Network Certification Requirements
Time and Distance Standards	-Exhaust all reasonable options for contracting with Providers in order to meet time and distance standards. - Submit Alternative Access Standard (AAS) requests if time and distance standards are not met. -Assist members with obtaining appointments with core specialists for appropriate core specialists for whom the AAS was approved. - Demonstrate how to arrange for Covered Services to Members through use of Non-Emergency Medical Transportation (NEMT), Non-Medical Transportation (NMT) and telehealth if time and distance standards are not met.	DHCS APL 20-003: Network Certification Requirements
Provider Screening and Enrollment	- DHCS and other designated State departments are required to enroll Network Providers. - MCPs must confirm that a provider is enrolled or not subject to provider enrollment prior to contracting with the Provider.	DHCS APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment
Network Provider Training	- Training must include information on ensuring telephone access for Members during hours of operation and regarding the Member's right to timely access to care.	

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Access and Availability	- Assist Members in obtaining in-person appointments within time and distance standards and appointment time standards before authorizing specialist services via telehealth. - Provision of non-urgent appointments with mental health providers within 10 business days of request. - Call center wait time must not exceed ten minutes. - Establishment of a nurse advice line to provide or arrange for triage or screening services by telephone 24 hours per day, 7 days per week with wait times not exceeding 30 minutes. - Provide notification to DHCS immediately upon discovery of and in any event, no later than 60 calendar days prior to making any changes in the availability or location of covered services. - MCPs unable to meet network adequacy standards due to changes in availability or location of covered services must receive written DHCS approval prior to implementing the change. - Ensure compliance with state and federal requirements regarding access for members with disabilities and language and communication assistance. -Subcontract with a sufficient number of CBAS providers to ensure timely access within the service area and provide list of subcontracted CBAS providers and CBAS accessibility standards to DHCS annually.	DHCS APL 19-009: Telehealth Services Policy DHCS APL 20-003: Network Certification Requirements DHCS APL 20-015: State Non-Discrimination and Language Assistance Requirements

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Covered Services	- Establishes that medically necessary services may be provided to members through telehealth. - Establishes that medically necessary services when applied to Members who are 21 years of age or older include all covered services that are reasonable and necessary to protect life, prevent, significant illness or significant disability, or alleviate severe pain through diagnosis or treatment of disease, illness or injury. -Establishes for those under 21 years of age that services are medically necessary if they meet the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity. Covered Services for these members are those that are necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. Contractor shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. - MCPs must arrange for any medically necessary treatment identified at a preventive screening or other visit. - Establishes that MCPs will be required to identify, at least quarterly, all children with no record of receiving a required lead test and remind the responsible health care provider of the requirement to test children. -Establishes that Behavioral Health Treatment (BHT) services may be discontinued when treatment goals are achieved, goals are not met, or services are no longer medically necessary. - Cover CBAS as a bundled service through CBAS provider or arrange for unbundled CBAS based on assessed needs of the member.	DHCS APL 19-010: Requirements for Coverage of EPSDT Services for Members Under the Age of 21 DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services DHCS APL 20-016: Blood Lead Screenings of Young Children DHCS APL 20-012: Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age of 21 DHCS APL 18-009: Memorandum of Understanding Requirements for Medi-Cal Managed Care Health Plans and Regional Centers

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Pharmacy Management	-MCPs' Drug Utilization Review (DUR) should be comparable to such programs administered by the State and must meet or exceed federal requirements including the implementation of Section 1004 requirements of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patient and Communities Act.	DHCS APL 19-012: Federal Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse
Written Member Information	-Establishes guidance on the implementation of nondiscrimination and language assistance requirements.	DHCS APL 17-011: Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act
Case Management	-Continue to provide case management services to ensure timely provision of all Medically Necessary treatment authorized through the CCS program. -As necessary, or upon Member's request, arrange for all in-home nursing hours authorized by the CCS program that the member desires to utilize.	DHCS APL 20-012: Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age of 21

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Community-Based Adult Services (CBAS)	-Subcontract with sufficient number of CBAS providers within service area and ensure timely access. -Provide DHCS with a list of subcontracted CBAS providers and accessibility standards on an annual basis. -Provide continuity of care for up to 12 months pursuant to continuity of care requirements. - Ensure CBAS Individual Plans of Care (IPCs) are consistent with Members' overall care plan and goals. - Ensure initial and reassessment procedures for Members requesting CBAS are conducted in accordance with 2020 Waiver Special Terms and Conditions. -Coordination of care, including unbundled services that are not covered services, based on assessed needs of the Member eligible for CBAS. -Inclusion of CBAS providers added or deleted from CalOptima's provider network within quarterly Provider Network Report submission.	

Grievance and Appeals	-Language Assistance Taglines and Nondiscrimination Notice accompanies each member notification and Nondiscrimination Notice must be available in threshold languages or ADA-complaint accessible format. -Establishes requirements that MCPs retain all documents used in the course of responding to Adverse Benefit Determinations, Grievances and Appeals for at least ten (10) years. - Establishes requirements that MCPs submit complete, accurate, reasonable, and timely Grievance and Appeal data within ten (10) calendar days following the end of each month. -Updated Notice of Action (NOA) criteria. - Updated State Fair Hearing (SFH) criteria. -MCPs must automatically continue providing covered services while the Appeal and SFH are pending under certain conditions. - MCPs must process a grievance for discrimination as required by federal and State nondiscrimination law.	DHCS APL 17-011: Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act DHCS APL 17-006: Grievance and Appeal Requirements, Notice Templates and "Your Rights" Attachments DHCS APL 20-015: State Non-Discrimination and Language Assistance Requirements

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Aid Code Categories	-Addition of aid code 2C (effective October 1, 2019) to Adult & Family/Optional Targeted Low-Income Child aid group category • 2C is a full-scope aid code for children 18 years of age or younger with a modified adjusted gross income above 266% and up and including 322% of United States Department of Health and Human Services (HHS) poverty guidelines. -Addition of aid code L6 to SPD aid group category. • L6 is a full-scope aid code for citizens and individuals with satisfactory immigration status with income at or below 128% of the Federal Poverty Line (FPL). • Staff received authority from the CalOptima Board of Directors to add aid code L6 to CalOptima's Primary Agreement with the DHCS during the August 2019 meeting of the CalOptima Board of Directors.	
Contract Provisions	- MCPs must comply with terms of each applicable Directed Payment Initiatives, Pass-Through Payments and Incentive Arrangements.	
Sanctions	- MCPs can be subject to monetary sanctions through identified findings of non-compliance or good cause as determined by DHCS.	DHCS APL 18-003: Administrative and Financial Sanctions
COVID-19 Risk Corridor	-Risk-sharing arrangement must be in effect for the rating period covering dates of services between July 1, 2019 and December 31, 2020. - Continuation of risk-sharing arrangement may continue to apply for rating periods on or after January 1, 2021 in a form and manner specified by DHCS if DHCS determines the arrangement is actuarily appropriate.	

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Contractor's Dispute Resolution Requirements	-MCPs must comply with and exhaust requirements of this section when it alleges a contract dispute with DHCS. -Outlines resolution of dispute by negotiation, notice of dispute, contracting officer's or alternate dispute officer's decision, appealing decisions, MCPs' duty to perform and waiver of claims.	

Fiscal Impact

The recommended action to execute an Amendment(s) to the Primary Agreement between DHCS and CalOptima related to the Bridge Period Contract is primarily operational in nature, and do not contain rate setting or rate adjustments. As such, Staff does not anticipate any additional fiscal impact to CalOptima. Given the long delay in CalOptima's receipt of the contract language changes, Staff has included updated aid codes in the applicable annual financial statements for Fiscal Year (FY) 2019-20 and FY 2020-21. To the extent there is any additional fiscal impact, such impact will be addressed in separate Board actions or in future operating budgets.

Rationale for Recommendation

CalOptima's execution of the July 1, 2019 to December 31, 2020 Bridge Period contract amendment to its Primary Agreement with DHCS is necessary for the continued operation of CalOptima's Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Appendix summary of amendments to Primary Agreements with DHCS
2. Bridge Period Amendment

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 10

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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
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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
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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
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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-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
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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
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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
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A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

V. Exhibit A, SCOPE OF WORK, Provision 2, is amended to read:

2. Service Location

The services shall be performed at all contracting and participating facilities of the Contractor **or**~~.~~ ~~Many services also may be provided~~ **through Telehealth, as appropriate**. ~~As defined in this contract and APL 19-009.~~

VI. Exhibit A, Attachment 1, ORGANIZATION AND ADMINISTRATION OF THE PLAN, Provision 3, is amended to read:

3. Conflict of Interest – Current And Former State Employees

A. This Contract shall be governed by the Conflict of Interest provisions of Title 22 CCR Sections 53874 and 53600, and 42 CFR 438. 3(f)(2).

B. Contractor shall not utilize in the performance of this Contract any State officer or employee in the State civil service or other appointed State official unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment. For purposes of this subsection (B) only, employee in the State civil service is defined to be any person legally holding a permanent **appointed** or intermittent position in the State civil service.

VII. Exhibit A, Attachment 4, QUALITY IMPROVEMENT SYSTEM, Provision 7, is amended to read:

7. Written Description

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

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

B. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QIS committee(s) and staff within ~~the~~ Contractor's organization.

C. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.

D. A description of the system for Provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and Providers, regarding QIS study outcomes.

E. The role, structure, and function of the quality improvement committee.

F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless ~~of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56~~ **sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56**, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that Members are able to obtain appointments within established standards **for time and distance, timely access, and alternative access as defined in APL 20-003, and W&I Code sections 14197 and 14197.04**.

VIII. Exhibit A, Attachment 6, PROVIDER NETWORK, is amended to read:

8. Time and Distance Standards

A. Contractor shall ~~maintain a Network of~~ **meet time and distance standards for** adult and pediatric PCPs, adult and pediatric core Specialists, OB/GYN primary and specialty care, **adult and pediatric** mental **outpatient** health Providers, hospitals, and pharmacies ~~which are located within the provider-specific time and distance standard as~~ **based on county population density and as** required ~~in~~ **by** Welfare and Institutions Code section 14197~~(e) and as decided and modified by DHCS. DHCS will evaluate and~~

~~approve exceptions to the Network standard by Provider type and for all Provider types covered under this Contract~~.

B. **Contractor must either exhaust all other reasonable options for contracting with Providers such as a Member-specific case agreement with an out-of-network Provider or demonstrate to DHCS that its delivery structure is capable of delivering the appropriate level of care and access as required by W&I Code section 14197 prior to submitting an Alternate Access Standard (AAS) request to DHCS to meet time and distance standards.**

C. If Contractor is unable to comply with the time and distance standards set forth in W&I section 14197, Contractor must submit an AAS request to DHCS for review and approval in accordance with APL 20-003 detailing how it intends to arrange for Covered Services in accordance with W&I section 14197(e)(3).

D. If Contractor has received an AAS approval for a core Specialist from DHCS, upon a Member's request Contractor shall assist the Member in obtaining an appointment with the appropriate core specialist in accordance with W&I Code section 14197.04. Contractor must either make its best effort to establish a Member-specific case agreement with an out-of-Network Provider or arrange for an appointment with a Network Provider in the next closest county within the time and distance standards in accordance with W&I Code 14197.04. If needed, Contractor must assist in arranging transportation for the Member. Contractor shall not be held liable for fulfilling these requirements if either there is no core Specialist within the time and distance standards of this Contract, or the core Specialist has refused such efforts within the previous 12 months.

9. Plan Physician Availability

Contractor shall have a plan or contracting physician available 24 hours per day, seven (7) days per week to coordinate the transfer of care of a Member whose emergency condition is stabilized, to authorize Medically

Necessary post-stabilization services, and for general communication with emergency room personnel.

10. Network Provider Availability

Contractor shall ensure that Network Providers offer hours of operation to Members that are no less than the hours of operation offered to other patients, or to Medi-Cal FFS beneficiaries, if the Network Provider serves only Medi-Cal beneficiaries.

11. Provider Network Reports

Contractor shall submit to DHCS, in a format specified by DHCS, a report summarizing changes in the Provider Network.

A. The report shall be submitted at a minimum:

1) Quarterly

2) At the time of a Significant Change, as defined in this Contract and set forth in 42 CFR 438.207 and APL~~19-002~~ **20-003**, to the Network affecting Provider capacity and services, including:

a) Change in services or benefits;

b) Geographic service area or payments;

c) The composition of, or the payments to, it's Network; or

d) Enrollment of a new population.

B. The report shall identify ~~number of Primary Care Providers, Provider deletions and additions, and~~ the **following for each termination** resulting **in a network** impact ~~to~~:

1) Geographic access **maps** for the Members;

~~2) Cultural and linguistic services including Provider and Provider staff language capability;~~

~~3~~**2**) The percentage of Traditional and Safety-Net Providers;

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4**3**) The number of Members assigned to each ~~Primary Care Physician~~ **provider type or facility**;

~~5~~**4**) The percentage of Members assigned to Traditional and Safety-Net Providers; and

~~6~~**5**) The Network Provider**s** who are not accepting new patients.

C. Contractor shall submit the report 30 calendar days following the end of the reporting quarter.

D. Contractor shall participate annually in the submission to DHCS of its Provider Network composition report to demonstrate its capacity to serve the current and expected membership in its Service Area in accordance with State standards for access and timeliness of care, 42 CFR 438.207(b), and APL ~~18-005~~ **20-003**.

1) **Contractor shall demonstrate how it will arrange for Covered Services to Members through the use of NEMT, NMT, and Telehealth if Contractor does not meet time and distance standards for adult and pediatric PCPs, core specialist and outpatient mental health providers in accordance with W&I section 14197(f)(2)**.

12. Plan Subcontractors

Contractor shall submit to DHCS, a quarterly report containing the names of all direct subcontracting provider groups including health maintenance organizations, independent physician associations, medical groups, and FQHCs and their subcontracting health maintenance organizations, independent physician associations, medical groups, and FQHCs. The report must be sorted by Subcontractor type, indicating the county or counties in which Members are served. In addition, the report should also indicate where relationships or affiliations exist between direct and indirect Subcontractors. The report shall be submitted within 30 calendar days following the end of the reporting quarter.

13. Ethnic and Cultural Composition

Contractor shall ensure that the composition of Contractor's Provider Network meets the ethnic, cultural, and linguistic needs of Contractor's Members on a continuous basis.

14. Subcontracts

Contractor may enter into Subcontracts with other entities in order to fulfill the obligations of the Contract. Contractor shall maintain policies and procedures, approved by DHCS, to ensure that Subcontractors fully comply with all terms and conditions of this Contract. Contractor shall evaluate the prospective Subcontractor's ability to perform the subcontracted services, shall oversee and remain responsible and accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements as stated in 42 CFR 438.230(b)(1), (c)(1)(i)-(iii), (c)(2), (c)(3), Title 22 CCR Section 53867, APL 17-004 ~~and any subsequent revisions,~~ and this Contract.

A. Laws and Regulations

All Subcontracts shall be in writing and in accordance with the requirements of the 42 CFR 438.230(c)(1)(i)-(iii), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 28, Section 1300 et seq.; Welfare and Institutions Code Section 14200 et seq.; Title 22 CCR Section 53800 et seq.; and other applicable federal and State laws and regulations.

B. Subcontract Requirements

Each Subcontract as defined in Exhibit E, Attachment 1, shall contain:

1) Specification of the services to be provided by the Subcontractor.

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

3) Specification that the Subcontract or Subcontract amendments shall become effective only as set forth in Paragraph C. Departmental Approval – Non-Federally Qualified HMOs, or Paragraph D, Departmental Approval – Federally Qualified HMOs.

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

5) Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Subcontractors at risk for non-contracting emergency services.

6) Subcontractor's agreement to submit reports as required by Contractor.

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

8) Subcontractor's agreement to make all of its premises, facilities, equipment, books, ~~and~~ records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Subcontract, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights:

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

   b) At all reasonable times at the Subcontractor's place of business or at such other mutually agreeable location in California.

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

   d) For a term of at least 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

   e) Including all Encounter Data for a period of at least 10 years.

   f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector

General may inspect, evaluate, and audit the Subcontractor at any time.

g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Subcontractor from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions **authorized by state and federal law, this Contract and** ~~provided under~~ the State Plan, and direct Contractor to terminate their Subcontract due to fraud.

9) Full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor from Contractor.

10) Subcontractor's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Subcontractor:

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

b) Retain all records and documents for a minimum of 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

11) Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 15. Phase out Requirements, Subparagraph B in the event of Contract termination.

12) Subcontractor’s agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.

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

14) Subcontractor's agreement that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.

15) Subcontractor's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract.

16) Subcontractor's agreement to timely gather, preserve, and provide to DHCS, any records in the Subcontractor's possession, in accordance with Exhibit E, Attachment 2, Provision 25. Records Related to Recovery for Litigation.

17) Subcontractor's agreement to provide interpreter services for Members at all Provider sites.

18) Subcontractor's right to submit a grievance and Contractor's formal process to resolve Provider Grievances.

19) Subcontractor's agreement to participate and cooperate in Contractor's Quality Improvement System.

20) If Contractor delegates Quality Improvement activities, Subcontract shall include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.

21) Subcontractor's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program.

22) Subcontractor's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Subcontractor has not performed satisfactorily.

23) To the extent that the Subcontractor is responsible for the coordination of care for Members, Contractor's agreement to share with the Subcontractor any utilization data that DHCS has provided to Contractor, and the Subcontractor's agreement to receive the utilization data provided and use as they are able for the purpose of Member care coordination.

24) Contractor's agreement to inform the Subcontractor of prospective requirements added by DHCS to this Contract before the requirement would be effective, and Subcontractor's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

C. Departmental Approval - Non-Federally Qualified HMOs

1) Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7 regarding Federally Qualified Health Centers and Rural Health Clinics, a Provider or management Subcontract entered into by Contractor which is not a federally qualified HMO shall become effective upon approval by DHCS in writing, or by operation of law where DHCS has acknowledged receipt of the proposed Subcontract, and has failed to approve or disapprove the proposed Subcontract within 60 calendar days of receipt. Within five (5) working days of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor for approval.

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

D. Departmental Approval - Federally Qualified HMOs

Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7 regarding Federally Qualified Health Centers and Rural Health Clinics, Subcontracts

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entered into by Contractor which is a federally qualified HMO shall be:

1) Exempt from prior approval by DHCS.

2) Submitted to DHCS upon request.

E. Public Records

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

15. Subcontracts with Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)

Subcontracts with FQHCs shall also meet Subcontract requirements of Provision 13 above and reimbursement requirements in Exhibit A, Attachment 8, Provision 7. In Subcontracts with FQHCs and RHCs where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the Subcontract.

16. Traditional and Safety-Net Providers Participation

Contractor shall establish participation standards pursuant to Title 22 CCR Section 53800(b)(2)(C)(1) to ensure participation and broad representation of Traditional and Safety-Net Providers within a Service Area. Contractor shall maintain the percentage of Traditional and Safety-Net Provider within a Service Area submitted and approved by DHCS. Federally Qualified Health Centers meet the definitions of both Traditional and Safety-Net Providers.

17. Safety-Net Provider~~s~~ Subcontracts

Contractor shall offer a Subcontract to any Safety-Net Provider that agrees to provide its scope of services in accord with the same terms and conditions that the Contractor requires of other similar Providers.

18. Termination of Safety-Net Provider Subcontract

Contractor shall notify DHCS of intent to terminate a Subcontract with a Safety-Net Provider at least 30 calendar days prior to the effective date of termination unless such ~~p~~**P**rovider's license has been revoked or suspended or where the health and welfare of a Member is threatened, in which event termination shall be effective immediately, without DHCS prior approval, and Contractor shall notify DHCS concurrently with the termination.

19. Nondiscrimination in Provider Contracts

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

20. Provider Screening and Enrollment

All Network Providers must be screened and enrolled in accordance with Title 42 CFR 438.602(b), and APL ~~17-019~~ **19-004,** ~~Contractor must screen and enroll Provider types that are not currently enrolled in Medi-Cal FFS if those Provider types are necessary to maintain an adequate Network. Contractor shall implement and maintain requirements for the screening~~

~~and enrollment of Network Providers and shall submit them to DHCS for review and approval.~~

A. DHCS, and other designated State departments, are required to enroll Network Providers in accordance with 42 CFR Section 438.602(b), APL 19-004. DHCS has provided Contractor with the option to enroll Network Providers under delegated authority in accordance with APL 19-004.

B. If Contractor elects to enroll Network Providers under its delegated authority, Contractor must screen and enroll Provider types for which there is an existing Medi-Cal Fee-For-Service state-level pathway. Contractor must also screen and enroll Provider types that are not currently enrolled in Medi-Cal FFS if those Provider types are necessary to maintain an adequate Network. Contractor shall confirm that a Provider is enrolled, or not subject to enrollment, prior to contracting with the Provider.

If Contractor elects to enroll Network Providers, Contractor shall implement and maintain requirements for the screening and enrollment of Network Providers consistent with 42 CFR Section 438.602(b), and APL 19-004,

IX. Exhibit A, Attachment 7, PROVIDER RELATIONS, Provision 5, is amended to read:

5. Network Provider Training

A. Contractor shall ensure that all Network Providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable federal and State statutes and regulations. Contractor shall ensure that Network Provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, Network Provider, Member and/or other healthcare professionals**, which includes ensuring accurate contact information. Training must also include maintaining operational standards for ensuring telephone access for Members during hours of operation.** Contractor shall conduct training for all Network Providers within ten (10) working days after Contractor places a newly contracted Network Provider on active status. Contractor shall ensure that Network Provider

training includes information on all Member rights specified in Exhibit A, Attachment 13, Member Services, including the right to full disclosure of health care information**,** ~~and~~ the right to actively participate in health care decisions **and the Member's right to timely access to care.** Contractor shall ensure that ongoing training is conducted when deemed necessary by either Contractor or the State.

X. Exhibit A, Attachment 9, ACCESS AND AVAILABILITY, is amended to read:

1. General Requirement

Contractor shall ensure that each Member has a Primary Care Provider who is available and physically present at the service site for sufficient time to ensure access for the assigned Member when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the Primary Care Provider in the event of vacation, illness, or other unforeseen circumstances.

Contractor shall ensure Members access to Specialists for Medically Necessary Covered Services. Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services will be provided in accordance with Title 22 CCR Section 53853(a) and consistent with all specified requirements.

Before authorizing Specialist services via an approved AAS, Contractor must assist Members in obtaining in-person appointments within the time and distance standards established pursuant to W&I Code, 14197(c) and the appointment time standards established pursuant to W&I Code 14197(d) as required by W&I Code 14197.04. Methods of obtaining an in-person appointment may include a Member-specific case agreement with an out-of-network Provider and/or provision of transportation to facilitate access to services. Contractor may assist Members in obtaining appointments via Telehealth, as established by W&I Code 14132.72 and detailed in APL 19-009.

2. Existing Patient-Physician Relationships

Contractor shall ensure that no Traditional or Safety-Net Provider, upon entry into Contractor's Network, suffers any disruption of existing patient-physician relationships, to the maximum extent possible.

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with **W&I Code section 14197,** Title 28 CCR Section**s** 1300.67.2.1 **and 1300.67.2.2,** and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor Network Providers' compliance with these requirements.

A. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

~~B. First Prenatal Visit~~

~~Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.~~

~~C~~**B**. Waiting Times

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in Network Providers' offices, telephone calls (**time** to answer and return), and time to obtain various types of appointments indicated in Paragraph A. Appointments, above.

~~D~~**C**. Telephone Procedures

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

~~E~~**D**. After Hours Calls

At a minimum, Contractor shall ensure that a physician or an appropriate licensed professional under his/her supervision will be available**, seven days a week,** for after-hours calls.

~~F~~**E**. Unusual Specialty Services

Contractor shall arrange for the provision of seldom used or unusual specialty services from Specialists outside the Network if unavailable within Contractor's Network, when determined Medically Necessary.

4. Access Standards

Contractor shall ensure **timely access to services** ~~the provision of acceptable accessibility standards~~ in accordance with **W&I Code section 14197,** Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor Network Providers' compliance with ~~these~~ **timely access** standards.

A. Appropriate Clinical Timeframes

Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their **health** condition.

B. Standards for Timely Appointments

Members must be offered appointments within the following timeframes:

1) Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;

2) Urgent appointment for services that do require prior authorization – within 96 hours of a request;

3) Non-urgent primary care appointments – within ten (10) business days of request;

4) Appointment with a Specialist – within 15 business days of request;

5) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

6) Non-urgent appointments with a non-physician mild to moderate mental health care provider – within ten business days of the request for appointment.

C. Shortening or Expanding Timeframes

Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of ~~his or her~~ **their** practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Member's medical record that a longer timeframe will not have a detrimental impact on the Member's health. **Contractor must ensure that documentation is available to DHCS upon request.**

D. Provider Shortage

Contractor shall arrange for a Member to receive timely care as necessary for their health condition if timely appointments within the time and distance standards required in Attachment 6, Provision 8 of this contract are not available. Contractor shall refer Members to, or assist Members in locating, available and accessible contracted Providers in neighboring service areas **or out-of-network providers** for obtaining health care services in a timely manner appropriate for the Member's needs.

E. Call Center Wait Time Standards

Contractor shall ensure that, during normal business hours, the waiting time for a Member to speak by telephone with a Contractor's customer service representative who is knowledgeable and competent regarding the Member's questions and concerns shall not exceed ten minutes as required by 28 CCR section 1300.67.2.2(c)(10).

F. Nurse Triage Line Standards

Contractor shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone and shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the Member's condition, and that the triage or screening waiting time does not exceed 30 minutes as required by 28 CCR section 1300.67.2.2(c)(8).

5. Access to Services to Which Contractor or Subcontractor Has a Moral Objection

Contractor shall arrange for the timely referral and coordination of Covered Services to which ~~the~~ Contractor or Subcontractor has religious

or ethical objections to perform or otherwise support. Contractor shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals at no additional expense to DHCS **or the Member**. Contractor shall identify these services in ~~the~~ **its** Member Services Guide.

6. Standing Referrals

Contractor shall ~~provide~~ **arrange** for standing referrals to Specialists, in accordance with Health and Safety Code Section 1374.16, as follows:

A. Contractor shall have in place a procedure for a Member to receive a standing referral to a Specialist if the primary care physician determines, in consultation with the Specialist and Contractor's Medical Director or the Medical Director's designee, that a Member needs continuing care from a Specialist. If a treatment plan is necessary in the course of care and is approved by Contractor, in consultation with the primary care physician, Specialist, and Member, a referral shall be made in accordance with the treatment plan. A treatment plan may be deemed unnecessary if Contractor approves a current standing referral to a Specialist. The treatment plan may limit the number of visits to the Specialist, limit the period of time that the visits are authorized, or require that the Specialist provide the primary care physician with regular reports on the health care provided to the Member.

B. Contractor shall have in place a procedure for a Member with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling to receive a referral to a Specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the Specialist coordinate the Member's health care. The referral shall be made if the primary care physician, in consultation with the Specialist or specialty care center and Contractor's Medical Director or the Medical Director's designee, determines that this specialized medical care is medically necessary for the Member. If a treatment plan is deemed necessary in the course of the care and is approved by Contractor, in consultation with the primary care physician, Specialist or specialty care center, and Member, a referral shall be made in accordance with the treatment plan. A treatment plan may be deemed unnecessary if Contractor approves the appropriate referral to a **S**pecialist or specialty care center.

C. Determinations for standing referrals shall be made within three (3) business days from the date the request is made by the Member or the Member's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four (4) business days of the date the proposed treatment plan, if any, is submitted to Contractor's Medical Director or the Medical Director's designee.

D. Standing referrals do not require Contractor to refer to a Specialist who, or to a specialty care center that, is not employed by or under contract with Contractor to provide health care services to Members, unless there is no Specialist within the Provider Network that is appropriate to provide treatment to Members, as determined by a primary care physician in consultation with Contractor's Medical Director as documented in the treatment plan.

7. Emergency Care

Contractor shall ensure that a Member with an emergency condition will be seen on an emergency basis and that emergency services will be available and accessible within the Service Area 24-hours-a-day.

A. Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section**s** 53216 **and 53855**. Contractor shall coordinate access to emergency care services in accordance with the Contractor's DHCS-approved emergency department protocol (see Exhibit A, Attachment 7, Provider Relations).

B. Contractor shall ensure adequate follow-up care for those Members who have been screened in the emergency room and require non-emergency care.

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

8. Nurse Midwife and Nurse Practitioner Services

Contractor shall meet Federal requirements for access to Certified Nurse Midwife (CNM) services as defined in Title 22 CCR Section 51345 and

Certified Nurse Practitioner (CNP) services as defined in Title 22 CCR Section 51345.1. Contractor shall inform Members that they have a right to obtain out-of-Network CNM services **if not available in-Network**.

9. Access to Services with Special Arrangements

A. Family Planning

Members have the right to access family planning services through any family planning Provider without prior authorization. Contractor shall provide family planning services in a manner that protects and ~~enables~~ **gives** Member**s the** freedom to choose the method of family planning to be used consistent with 42 CFR 441.20. Contractor shall inform its Members in writing of their right to access any qualified family planning Provider without prior authorization in its Member Services Guide. See Exhibit A, Attachment 13, Member Services.

1) Informed Consent

Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22 CCR Sections 51305.1 and 51305.3.

2) Out-Of-Network Family Planning Services

Members of childbearing age may access the following services from ~~o~~ **O**ut-of-Network family planning Providers to temporarily or permanently prevent or delay pregnancy:

a) Health education and counseling necessary to make informed choices and understand contraceptive methods.

b) Limited history and physical examination.

c) Laboratory tests if medically indicated as part of decision-making process for choice of contraceptive methods. Contractor shall not be required to reimburse Out-of-Network Providers for pap smears, if Contractor has provided pap smears to meet the U.S. Preventive Services Task Force guidelines.

d) Diagnosis and treatment of a sexually transmitted disease episode, as defined by DHCS for each sexually transmitted disease, if medically indicated.

e) Screening, testing, and counseling of at risk individuals for HIV and referral for treatment.

f) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider.

g) Provision of contraceptive pills, devices, and supplies.

h) Tubal ligation.

i) Vasectomies.

j) Pregnancy testing and counseling.

B. Sexually Transmitted Diseases (STDs)

Contractor shall provide access to STD services without prior authorization to all Members both within and outside its Provider Network. Members may access out-of-Network STD services through local health department (LHD) clinics, family planning clinics, or through other community STD service Providers. Members may access LHD clinics and family planning clinics for diagnosis and treatment of a STD episode. For community Providers other than LHD and family planning Providers, out-of-Network services are limited to one office visit per disease episode for the purposes of: (1) diagnosis and treatment of vaginal discharge and urethral discharge, (2) those STDs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale and (3) evaluation and treatment of pelvic inflammatory disease. Contractor shall provide follow-up care.

C. HIV Testing and Counseling

Members may access confidential HIV counseling and testing services through Contractor's Provider Network and through the

~~o~~**O**ut-of-Network local health department and family planning Providers.

D. Minor Consent Services

Contractor shall ensure the provision of Minor Consent Services for individuals under the age of 18. Minor Consent Services shall be available within the Provider Network and Members shall be informed of the availability of these services. Minors do not need parental consent to access these services. Minor Consent Services are services related to:

1) Sexual assault, including rape.

2) Drug or alcohol abuse for children 12 years of age or older.

3) Pregnancy.

4) Family planning.

5) Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.

6) Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others, or (2) the children are the alleged victims of incest or child abuse.

E. Immunizations

Members may access LHD clinics for immunizations. Contractor shall, upon request, provide updated information on the status of Members' immunizations to the LHD clinic. The LHD clinic shall provide immunization records when immunization services are billed to the Contractor.

F. American Indian Health Services Programs

Contractor shall ensure Members have access to American Indian Health Services Programs pursuant to, and in compliance with all requirements of 42 USC Section 1396o(a), and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009. American Indian Health Service Programs, whether a Network Provider or Out-of-Network Provider, can provide referrals directly

to Network Providers without first requesting a referral from a Network Primary Care Provider. Contractor shall ensure timely access to American Indian Health Service Programs by including American Indian Health Service Programs within Contractor's Network for American Indian Members, as well as permitting access to out-of-Network American Indian Health Service Programs, in accordance with 42 CFR 438.14(b).

10. Changes in Availability or Location of Covered Services

Contractor ~~shall~~ **must** provide notification to DHCS **immediately upon discovery of and in any event, no later than** 60 calendar days prior to making any change in the availability or location of services to be provided under this Contract. In the event of an emergency or other unforeseeable circumstances, Contractor shall provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

Network changes as outlined in APL 20-003 due to the change in the availability of location of Covered Services require written approval from DHCS prior to implementing the change.

11. Access for ~~Disabled~~ Members with Disabilities

Contractor~~'s facilities~~ shall comply with the requirements of ~~T~~**t**itle**s II and** III of the Americans with Disabilities Act of 1990, **section 1557 of the Affordable Care Act of 2010, section s504 and 508 of the Rehabilitation Act of 1973, Government Code sections 11135 and 7405, and all applicable implementing regulations,** and shall ensure access for ~~the disabled~~ **people with disabilities** which includes, but is not limited to, **accessible web content,** ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

12. ~~Civil Rights Act of 1964~~ Language and Communication Assistance

Contractor shall ensure compliance with **all state and federal language and communication assistance requirements, including, without limitation, section 1557 of the Affordable Care Act of 2010 (42 U.S. Code § 18116, 45 C.F.R. Part 92)** ~~T~~**t**itle ~~6~~**VI** of the Civil Rights Act of 1964 (42 USC Section 2000d, 45 C.F.R. Part 80)**, section 438.10 of title 42 of the Code of Federal Regulations, Government Code section 11135, and W&I Code section 14029.91** ~~that prohibits recipients of Federal~~

~~financial assistance from discriminating against persons based on race, color, religion, or national origin~~.

Contractor shall ensure equal access to health care services for ~~l~~**L**imited English ~~p~~**P**roficient **(LEP)** ~~Medi-Cal~~ Members or Potential Enrollees **and Members or Potential Enrollees with disabilities,** through provision of high quality interpreter and linguistic services **in compliance with federal and state law, and APL 20-015**.

13. Cultural and Linguistic Program

Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22 CCR Section 53876. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the population needs assessment (~~GNA~~ **PNA**) requirements stipulated below.

A. Written Description

Contractor shall implement and maintain a written description of its Cultural and Linguistic Services Program, which shall include at minimum the following:

1) An organizational commitment to deliver culturally and linguistically appropriate health care services.

2) Goals and objectives.

3) A timetable for implementation and accomplishment of the goals and objectives.

4) An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities. A narrative shall explain the chart and describe the oversight and direction to the Community Advisory Committee, provisions for support staff, and reporting relationships. Qualifications of staff, including appropriate education, experience and training shall also be described.

5) Standards and Performance requirements for the delivery of culturally and linguistically appropriate health care services.

B. Linguistic Capability of Employees

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

C. ~~Group Needs Assessment (GNA)~~ **Population Needs Assessment (PNA)**

Contractor shall conduct a ~~GNA~~ **PNA**, as specified below, to identify the health education and cultural and linguistic needs of its' Members; and utilize the findings for continuous development and improvement of contractually required health education and cultural linguistic programs and services. Contractor must use multiple reliable data sources, methodologies, techniques, and tools to conduct the ~~GNA~~ **PNA**.

1) Contractor shall conduct an initial ~~GNA~~ **PNA** within 12 months from the commencement of operations within a Service Area and at least every five (5) years from the commencement of operations thereafter. For Contracts existing at the time this provision becomes effective, the next ~~GNA~~ **PNA** will be required at a time within the five (5) year period from the effective date of this provision, to be determined by DHCS.

2) Contractor shall submit a ~~GNA~~ **PNA** Summary Report to the DHCS within six (6) months of the completion of each ~~GNA~~ **PNA**. The summary report must include:

a) The objectives; methodology; data sources; survey instruments; findings and conclusions; program and policy implications; and references contained in the ~~GNA~~ **PNA**.

b) The findings and conclusions must include the following information for Medi-Cal plan Members: 1) demographic profile; 2) related health risks, problems and conditions; 3) related knowledge, attitudes and practices including cultural beliefs and practices; 4) perceived health education needs including learning needs, preferred methods of learning and literacy level; and 5) culturally competent community resources.

3) Contractor shall annually update the ~~GNA~~ **PNA** summary report, including a current update on the information required in item 2) b) above. Contractor shall maintain, and have available for DHCS review, the ~~GNA~~ **PNA** summary report updates.

4) Contractor shall demonstrate that ~~GNA~~ **PNA** and summary report findings and conclusions in item 2) b) above are utilized for continuous development of its health education and cultural and linguistic services program. Contractor must maintain documentation of program priorities, target populations, and program goals/objectives as they are revised to meet the identified and changing needs of the Member population.

D. The results of the ~~GNA~~ **PNA** shall be considered in the development of any Marketing or promotional materials prepared by Contractor.

E. Cultural Competency Training

Contractor shall provide cultural competency, sensitivity, or diversity training for staff, Network Providers, and Subcontractors at key points of contact. The training shall promote access and the delivery of services in a culturally competent manner to all Members, regardless of ~~race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56~~ **sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56**. The training shall cover information about the identified cultural groups in the Contractor's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider is trying to do to treat the patient; and, language and literacy needs.

F. Program Implementation and Evaluation

Contractor shall develop and implement policies and procedures for assessing the performance of individuals who provide linguistic

services as well as for overall monitoring and evaluation of the Cultural and Linguistic Services Program.

14. Linguistic Services

A. Contractor shall comply with Title 22 CCR Section 53853(c) and (d), and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Enrollees receive 24-hour oral interpreter services at all key points of contact, as defined in Paragraph D of this provision, either through interpreters, telephone language services, or any electronic options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.

B. Contractor shall comply with 42 CFR 438.10(d)(4) and provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or Potential Enrollees:

1) Oral Interpreters, signers, or bilingual Providers and Provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal Members and Potential Enrollees and not limited to those that speak the threshold or concentration standards languages.

2) Fully translated Member information, including but not limited to the Member Services Guide, welcome packets, marketing information, and form letters including NOA letters and Grievance and Appeal acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within Contractor's Service Area, and by ~~the~~ Contractor in its ~~GNA~~ **PNA**.

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

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

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

1) A population group of ~~mandatory~~ Eligible Beneficiaries residing in Contractor's Service Area who indicate their primary language as a language other than English, and that meet a numeric threshold of 3,000 or five percent (5%) of the Eligible Beneficiaries population, whichever is lower.

2) A population group of ~~mandatory~~ Eligible Beneficiaries residing in Contractor's Service Area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes.

D. Key points of contact include:

1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care Providers including pharmacists.

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

XI. Exhibit A, Attachment 10, SCOPE OF SERVICES, is amended to read:

1. Covered Services

A. Contractor shall provide or arrange for all Medically Necessary Covered Services for Members. Covered Services are those services set forth in Title 22 CCR Chapter 3, Article 4, beginning with Section 51301, Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, and provided in accordance 42 CFR 438.210(a) and 42 CFR 440.230, unless otherwise specifically excluded under the terms of this Contract. Contractor shall ensure that the Covered Services and other services required in this Contract are provided to a Member in an amount no less than what is offered to beneficiaries under FFS. Contractor has the primary responsibility to provide all Medically Necessary Covered Services, including services, which exceed the

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services provided by Local Education Agencies (LEA), Regional Centers, or local governmental health programs.

B. Contractor shall ensure that services provided are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the Covered Services are furnished, and may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a service on the basis of criteria such as Medical Necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and the services supporting Members with ongoing or chronic conditions, or who require MLTSS, are provided in a manner that reflects the Member's ongoing needs.

C. Except as set forth in Attachment 3.1.B.1 (effective 1/1/2006) of the California Medicaid State Plan or as otherwise authorized by Welfare and Institutions Code Section 14133.23, effective January 1, 2006, drug benefits for Full Benefit Dual Eligible Members who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 USC Section 1395w-101 et seq) are not a Covered Service under this Contract. Consequently, effective January 1, 2006, the capitation rates shall not include reimbursement for such drug benefits and existing capitation rates shall be adjusted accordingly, even if the adjustment results in a change of less than one percent of cost to Contractor. Additionally, Contractor shall comply with all applicable provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, 42 USC Section 1395(x) et seq.

D. In addition to services covered under the California Medicaid State Plan, Contractor shall cover any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits and ensure that Members are given access to all mental health and substance use disorder benefits in accordance with 42 CFR 438.900 et seq. The types, amount, duration, and scope of these services must be consistent with the parity compliance analysis conducted by either DHCS or Contractor.

1) If Contractor provides Members with mental health or substance use disorder services in any classification of benefits as described in 42 CFR 439.910(b)(2), then Contractor must provide to Members those services in every classification that is listed therein and is covered by Contractor. In determining the classification in which a

particular benefit belongs, Contractor must apply the same reasonable standards for medical/surgical benefits to mental health or substance use disorder benefits.

2) Contractor shall provide referrals for all non-covered mental health and substance use disorder services.

E. Medically Necessary Covered Services may be provided to Members through Telehealth, as defined in W&I 14132.72, APL 19-009.

2. Medically Necessary Services

For purposes of this Contract, the term "Medically Necessary" **when applied to Members 21 years of age or older** will include all Covered Services that are reasonable and necessary to protect life, prevent **significant** illness or **significant** disability, **or** alleviate severe pain through the diagnosis or treatment of disease, illness or injury, ~~achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per~~ **as required under W&I Code 14059.5(a) and** Title 22 CCR Section 51303(a) ~~and 42 CFR 438.210(a)(5)~~. **Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.**

~~When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v).~~ **For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W & I Code Section 14132 (v). Without limitation, Medically Necessary Services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. Contractor shall determine**

Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

3. Initial Health Assessment (IHA)

An Initial Health Assessment (IHA) consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a Provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract.

A. Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22 CCR Section 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

B. Contractor shall ensure that the IHA includes an IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A, 10) using an age appropriate DHCS-approved assessment tool. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA.

C. Contractor shall ensure that Members' completed IHA and IHEBA tool are contained in the Members' medical record and available during subsequent preventive health visits.

D. Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.

4. Health Risk Stratification and Assessment for SPD Beneficiaries

Contractor shall apply a DHCS approved health risk stratification mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher risk and more complex health care needs within 44 days of enrollment. Based on the results of the health risk stratification, Contractor shall also administer the DHCS approved health risk assessment survey within 45 days for SPD beneficiaries deemed to be at a higher health risk, and 105 days for those determined to be a lower health risk. The health

risk stratification and assessment shall be done in accordance with W & I Code Sections 14182 (c)(11) to (13) and APL 17-013.

5. Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of **all** screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age ~~including~~ **required under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** services ~~listed under~~ **benefit described in** 42 USC Section 1396d(r), and Welfare and Institutions Code, Section 14132(v)~~,~~**. The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments and other measures listed in 42 USC Section 1396d(a), whether or not covered under the State Plan. All EPSDT services are Covered Services,** unless ~~otherwise~~ excluded under this Contract.

~~Contractor shall ensure that appropriate diagnostic and treatment services are initiated as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.~~

A. Provision of IHAs for Members under Age 21

1) For Members under the age of 18 months, Contractor shall ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) **Bright Futures** for ages two and younger whichever is less.

2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

3) ~~Contractor shall ensure that performance of the California Child Health and Disability Prevention (CHDP) program's age appropriate assessment due for each child at the time of enrollment is accomplished at the IHA.~~ The initial assessment **IHA** must include, or arrange for provision of, all immunizations necessary to ensure that the child is up-to-date for age, and an age appropriate IHEBA. See PL 13-001 **and any subsequent amendments** for specific IHEBA requirements.

B. Children's Preventive Services

1) Contractor shall provide preventive health visits for all Members under 21 years of age at times specified by the most recent AAP **Bright Futures** periodicity schedule ~~(Bright Futures guidelines)~~ and anticipatory guidance as outlined in the AAP Bright Futures periodicity schedule. ~~This schedule requires more frequent visits than does the periodicity schedule of the CHDP program.~~ Contractor shall provide, as part of the periodic preventive visit, all age specific assessments and services required by ~~the CHDP program~~ **AAP Bright Futures** and the age-specific IHEBA as necessary.

~~2) Where the AAP periodicity exam schedule is more frequent than the CHDP periodicity examination schedule, Contractor shall ensure that the AAP scheduled assessment includes all assessment components required by the CHDP for the lower age nearest to the current age of the child.~~

~~3~~**2**) Where a request is made for children's preventive services by the Member, the Member's parent(s) or guardian or through a referral from the local **Child Health and Disability Prevention (**CHDP**)** program, an appointment shall be made for the Member to be examined within two weeks of the request.

~~4~~**3**) At each non-emergency primary care encounter with Members under the age of 21 years, the Member (if an emancipated minor) or the parent(s) or guardian of the Member shall be advised of the children's preventive services due and available from Contractor, if the Member has not received children's preventive services in accordance with ~~CHDP~~**AAP Bright Futures** preventive standards ~~for children of the Members' age~~. Documentation shall be entered in the Member's Medical Record which shall indicate the receipt of children's preventive services in accordance with the ~~CHDP~~ **AAP Bright Futures** standards or proof of voluntary refusal of these services in the form of a signed statement by the Member (if an emancipated minor) or the parent(s) or guardian of the Member. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

~~5~~**4**) ~~The Confidential Screening/Billing Report form, PM 160-PHP, or any other system or format implemented by DHCS, shall be used to report all~~ **All** children's preventive services ~~Encounters, in addition to the~~ **shall be reported as part of the** Encounter Data submittal required in Exhibit A, Attachment 3, Management Information System Capability, Provision 2. Encounter Data Submittal. ~~Contractor shall submit completed forms to DHCS and to the local children's preventive services program within the timeframe specified by DHCS.~~

C. Immunizations

Contractor shall ensure that all children receive necessary immunizations at the time of any health care visit. Contractor shall cover and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP). Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the immunization shall be considered sufficient in meeting this requirement.

If immunizations cannot be given at the time of the visit, the Member must be ~~instructed as to~~ **informed on** how to obtain necessary immunizations or ~~a~~ scheduled and documented **a future** appointment **for immunizations** must be made **at the time of that visit**.

Appropriate documentation shall be entered in the Member's Medical Record ~~that, indicates~~ **indicating** all attempts to provide immunization(s); instructions as to how to obtain necessary immunizations; the receipt of vaccines or proof of prior immunizations; or proof of voluntary refusal of vaccines in the form of a signed statement by the Member (if an emancipated minor) or the ~~P~~**p**arent(s) or guardian of the Member. If the ~~responsible party~~ **Member or authorized representative** refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

Contractor shall ensure that Member-specific immunization information is reported to an immunization registry(ies) established in Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports shall be made following the Member's IHA and all other health care

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visits that result in an administered immunization. Reporting shall be in accordance with all applicable State and Federal laws.

Upon Federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, Contractor shall develop policies and procedures for the provision and administration of the vaccine. **Contractor shall develop** ~~S~~**s**uch policies and procedures ~~shall be developed~~ within ~~thirty~~ ~~(~~30~~)~~ calendar days of the vaccine's approval date. Contractor shall cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies and procedures must be in accordance with any Medi-Cal FFS guidelines issued prior to final ACIP recommendations.

Contractor shall provide information to all Network Providers regarding the VFC Program.

D. Blood Lead Screens

Contractor shall cover and ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with Title 17, Division 1, Chapter 9, Articles 1 and 2, commencing with Section 37000~~.~~ **and in accordance with APL 20-016**. Contractor shall **ensure their contracted providers follow the CLPPB guidelines when interpreting blood lead levels and determining appropriate follow-up activities** ~~document and appropriately follow up on blood lead screening test results~~. **Contractor will be required to identify, at least quarterly, all children with no record of receiving a required lead test, and remind the responsible health care provider of the requirement to test children.**

~~Contractor shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide test.~~ If the **Member refuses the** blood lead screen test ~~is refused by the Member~~, **Contractor shall ensure** ~~proof of voluntary refusal of the test in the form of~~ a signed statement **of voluntary refusal** by the Member (if an emancipated minor) or the ~~P~~**p**arent(s) or guardian of the Member is ~~shall be~~ documented in the Member's Medical Record. If the **Member or** ~~responsible party~~ **authorized representative** refuses to sign ~~this~~ **the** statement, the refusal shall be noted in the Member's Medical Record. Documented

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unsuccessful attempts **to provide the lead screen test** ~~that demonstrate Contractor's unsuccessful efforts to provide the blood lead screen test~~ shall be considered evidence **of Contractor** ~~in~~ meeting this requirement.

~~E. Screening for Chlamydia~~

~~Contractor shall screen all females less than 21 years of age, who have been determined to be sexually active, for chlamydia. Follow up of positive results must be documented in the medical record.~~

~~Contractor shall make reasonable attempts to contact the appropriately identified Members and provide screening for chlamydia. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and screen for chlamydia shall be considered evidence in meeting this requirement.~~

~~If the Member refuses the screening, proof of voluntary refusal of the test in the form of a signed statement by the Member (if an emancipated minor) or the Parent(s) or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.~~

~~F~~ **E**. Early and Periodic Screening, ~~Diagnosis~~ **Diagnostic** and Treatment (EPSDT) Services

For Members under the age of 21 years, Contractor shall provide or arrange and pay for **all Medically Necessary** EPSDT services, **including all Medicaid services listed in 42 USC Section 1396d(a), whether or not covered under the State Plan,** unless ~~otherwise~~ **expressly** excluded in this Contract. ~~Covered Services include all Medically Necessary services, as defined in 42 USC Section 1396d(r), and Welfare and Institutions Code, Section 14132(v).~~ Covered Services shall include **without limitation, in-home nursing provided by home health agencies or individual nurse providers, as required by APL 20-012, care coordination,** case management, ~~as well as~~ **and** Targeted Case Management **(TCM)** services as defined in Attachment 11, Provision 3 of this Contract. **If Members under age 21 are not eligible for or accepted for Medically Necessary TCM services by a Regional Center or local government health program, Contractor shall**

ensure the Members' access to comparable services under the EPSDT benefit in accordance with APL 19-010.

Contractor shall arrange for any Medically Necessary treatment identified at a preventative screening or other visit identifying the need for treatment, either directly or through referral to appropriate agencies, organizations, or individuals, as required by 42 U.S.C. section 1396a(a)(43)(C). Contractor shall ensure that all Medically Necessary services are provided in a timely manner, as soon as possible but no later than 60 calendar days following the preventive screening or other visit identifying a need for treatment, whether or not the services are Covered Services under this Contract. Without limitation, Contractor shall identify available Providers, including if necessary Out-of-Network Providers and individuals eligible to enroll as Medi-Cal Providers, to ensure the timely provision of Medically Necessary services. Contractor ~~is required to~~ **shall** provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for Medically Necessary ~~Covered~~ S**s**ervices**, including all services through the Medi-Cal program, whether or not they are Covered Services under this Contract** ~~that Contractor is responsible for providing pursuant to this Contract~~.

~~Contractor shall also ensure that appropriate EPSDT services are initiated in a timely manner, as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.~~

Covered Services do not include California Children's Services (CCS) pursuant to Exhibit A, Attachment 11, Provision 9, regarding CCS, or mental health services pursuant to **Exhibit A, Attachment 11, Provision 6 (subject to** Provision 8 below**)**, regarding **Specialty** Mental Health Services. Contractor shall ~~determine the Medical Necessity of EPSDT services using the criteria established in 42 USC Section 1396d(r), and Welfare and Institutions Code, Section 14132(v)~~ **ensure that the case management for Medically Necessary services authorized by CCS or county mental health agencies under this paragraph is equivalent to that provided by Contractor for Covered Services for Members under the age 21 under this Contract and shall, if indicated or upon the Member's request provide additional care coordination and case management services as necessary to meet the Member's medical needs**.

~~G~~ **F**. Behavioral Health Treatment (BHT) Services

For Members under 21 years of age, Contractor shall cover Medically Necessary BHT services **regardless of diagnosis** as ~~required in Section 1905(r) of the Social Security Act under the Early and Periodic Screening, Diagnostic and Treatment benefit, defined in the federally approved State Plan, and in accordance with Welfare and Intuitions Code Section 14132.56, Health and Safety Code sections 1374.72 and 1374.73, 28 California Code of Regulations 1300.74.72, APL 15-019, and APL 15-025 and APL 18-006, and APL 18-008 to the extent that they are consistent with the State Plan. These APLs, superseding APL 15-019 and APL 15-025 that as identified in the Provision, clarify the delivery of BHT services and shall be incorporated herein by this reference and become part of this Contract as of their effective date~~ **part of the EPSDT benefit**.

1) Contractor shall provide Medically Necessary BHT services **in accordance with a recommendation from a licensed Physician and surgeon, or a licensed psychologist** ~~as stated in the Member's treatment plan and/or~~ **and shall provide** continuation of BHT services under continuity of care.

2) The behavioral treatment plan must be reviewed, revised, and/or modified no less than every six (6) months by a BHT ~~service~~ Provider**.** ~~as defined by Health and Safety Code Section 1374.73(c)(3) and by the federally approved State Plan Amendment.~~ The behavioral treatment plan may be modified if Medically Necessary. BHT services may be discontinued when the treatment goals are achieved**,** goals are not met, **or** services are no longer Medically Necessary **under the EPSDT medical necessity standard**.

~~3) Contractor shall provide continuity of care for Members diagnosed with ASD who are transitioning from the regional centers to receive Medically Necessary BHT services as stated in Paragraph G.3) of this Provision.~~

~~a) For Members who had received BHT through a regional center prior to September 15, 2014, Contractor shall not provide Medically Necessary BHT services until such time as the Member may be safely transitioned into Contractor's Provider Network in~~

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~~accordance with the BHT services transition plan approved by DHCS and the Department of Developmental Services (DDS). If a Member, or a Member's parent or legal guardian, chooses to access Medically Necessary BHT services from Contractor's Network Provider prior to the transition of regional center clients to the Contractor for BHT services, Contractor shall provide Medically Necessary BHT services from Contractor's Network Provider.~~

~~b) For Members without an Autism Spectrum Disorder (ASD) diagnosis who had received BHT services through a regional center, Contractor shall not provide Medically Necessary BHT services until July 1, 2018, or the date the transition of regional center clients to Contractor for Medically Necessary BHT services occurs. Members may not access Medically Necessary BHT services from Contractor's Network Provider prior to the transition.~~

~~c) If Members received BHT services outside of Contractor's Network prior to the transition date, and the Member or the Member's parent or legal guardian request continued access to their existing BHT Provider, Contractor shall ensure continuity of care in accordance with APL 18-006 and APL 18-008.Contractor must offer continuity of care with an out-of-Network BHT Provider if all of the following conditions are met:~~

~~i. The Member has an existing relationship with a Provider. An existing relationship means the Member has seen an out-of-Network BHT Provider at least one (1) time during the six (6) months prior to Contractor assuming responsibility of BHT services from the regional center or the date of the Member's initial enrollment with Contractor if enrollment occurred on or after September 15, 2014;~~

~~ii. The Provider agrees to Contractor's rate or the Medi-Cal FFS rate, whichever is higher, for the appropriate BHT service;~~

~~iii. The Provider does not have any documented quality of care issues that would cause exclusion from Contractor's Network;~~

~~iv. The Provider is a qualified Provider under Health & Safety Code Section 1374.73 and the approved State Plan Amendment; and~~

~~v. The Provider supplies Contractor with all relevant treatment information, for purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.~~

~~d) Contractor shall continue to authorize Medically Necessary BHT services in accordance with the Member's treatment plan at the time of the request for continuity of care during the continuity of care period as described in APL 18-006.~~

~~e) Contractor's Network Provider may update the BHT treatment plan upon completion of an assessment and discontinue BHT services if the evaluation determines that BHT services are not Medically Necessary.~~

~~4)~~ ~~Contractor shall provide all necessary Member treatment information to the Member's regional center to enable care coordination, as permitted by federal and State law, APL 18-009, and this Contract.~~

~~5~~**3**) Contractor shall enter into a Memorandum of Understanding (MOU) with each local regional center in accordance with Exhibit A, Attachment 12, Provision 2 of this Contract, to facilitate the coordination of services for Members with developmental disabilities, including ~~ASD~~ **Autism Spectrum Disorder (ASD)**, as permitted by federal and State law, and specified by DHCS in APL 18-009. If Contractor is unable to enter into an MOU **or a one-time case agreement**, Contractor shall inform DHCS why **it could not reach an** agreement with the regional center ~~was not reached~~ and **shall** demonstrate**,** ~~that~~ **by providing all evidence of contracting efforts,** a good faith effort ~~was made by~~

~~Contractor~~ to enter into an ~~MOU~~ **agreement** with the regional center.

6. Services for Adults

A. IHAs for Adults (Age 21 and older)

1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:

a) blood pressure,

b) height and weight,

c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,

d) clinical breast examination for women over 40,

e) mammogram for women age 50 and over,

f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,

g) Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,

h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,

i) IHEBA.

B. Adult Preventive Services

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

1) Contractor shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult Members [age 21 or older]. All preventive services identified as USPSTF "A" and "B" recommendations must be provided. For tobacco use prevention and cessation services, Contractor may use either the USPSTF recommendations or the latest edition of the US Public Health Service "Treating Tobacco Use and Dependence: A Clinical Practice Guideline." As a result of the IHA or other examination, discovery of the presence of risk factors or disease conditions will determine the need for further follow-up, diagnostic, and/or treatment services. In the absence of the need for immediate follow-up, the core preventive services identified in the requirements for the IHA for adults described above shall be offered in the frequency required by the USPSTF Guide to Clinical Preventive Services.

2) Contractor shall cover and ensure the provision of all Medically Necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA or during visits for routine, urgent, or emergent health care situations. Contractor shall ensure that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.

C. Immunizations

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

In addition, Contractor shall cover and ensure the provision of age and risk appropriate immunizations in accordance with the findings

of the IHA, other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment.

Contractor shall document attempts to provide immunizations. If the Member refuses the immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the Member or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record. Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the immunization shall be considered evidence in meeting this requirement.

7. Pregnant Women

A. Prenatal Care

Contractor shall cover and ensure the provision of all Medically Necessary services for pregnant women. Contractor shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized to provide, at a minimum, quality perinatal services.

B. Risk Assessment

Contractor shall implement a comprehensive risk assessment tool for all pregnant female Members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22 CCR Section 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record.

C. Referral to Specialists

Contractor shall ensure that pregnant women at high risk of a poor pregnancy outcome are referred to appropriate Specialists including perinatologists and have access to genetic screening with appropriate referrals. Contractor shall also ensure that appropriate

hospitals are available within the Provider Network to provide necessary high-risk pregnancy services.

8. Services for All Members

A. Health Education

1) Contractor shall implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Members.

2) Contractor shall ensure administrative oversight of the health education system by a qualified full-time health educator.

3) Contractor shall provide health education programs and services at no charge to Members directly and/or through Subcontracts or other formal agreements with Providers that have expertise in delivering health education services to the Member population.

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

5) Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.

6) Contractor shall maintain a health education system that provides educational interventions addressing the following health categories and topics:

a) Appropriate use of health care services – managed health care; preventive and primary health care; obstetrical care; health education services; and, complementary and alternative care.

b) Risk-reduction and healthy lifestyles – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and, parenting.

c) Self-care and management of health conditions – pregnancy; asthma; diabetes; and, hypertension.

7) Contractor shall ensure that Members receive point of service education as part of preventive and primary health care visits. Contractor shall provide education, training, and program resources to assist contracting medical Providers in the delivery of health education services for Members.

8) Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of Providers that are contracted to deliver health education services to ensure effectiveness.

9) Contractor shall periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements.

10) Contractor shall ensure that all new Members complete the IHEBA within 120 calendar days of enrollment as part of the IHA; and that all existing Members complete the IHEBA at their next non-acute care visit. Contractor shall ensure: 1) that Primary Care Providers use the DHCS standardized "Staying Healthy" assessment tools, or alternative approved tools that comply with DHCS approval criteria for the IHEBA; and 2) that the IHEBA tool is: a) administered and reviewed by the Primary Care Provider during an office visit, b) reviewed at least annually by the Primary Care Provider with Members who present for a scheduled visit, and c) re-administered by the Primary Care Provider at the appropriate age-intervals.

11) Contractor shall cover and ensure provision of comprehensive case management including coordination of care services as described in Exhibit A, Attachment 11.

B. The Health Information Form (HIF)/Member Evaluation Tool (MET)

Contractor shall use data from a Health Information Form (HIF)/Member Evaluation Tool (MET) to help identify newly enrolled

Members who may need expedited services. In accordance with 42 CFR 438.208(b), Contractor shall, at a minimum, comply with the following:

1) Mail a DHCS-approved HIF/MET to all new Members as a part of Contractor's welcome packet and include a postage paid envelope for response.

2) Within 90 days of each new Member's effective date of enrollment:

   a) Make at least two (2) telephone call attempts to remind new Members to return the HIF/MET and/or collect the HIF/MET information from new Members. This outreach can be done through head of household for Members under the care of parents, custodial parents, legal guardians, or other authorized representatives in accordance with applicable privacy laws.

   b) Conduct an initial screening of the Member's needs as identified in the HIF/METs received. To meet this requirement, Contractor may build upon any existing screening process currently used to meet requirements in Exhibit A, Attachment 10, Scope of Services, or Exhibit A, Attachment 11, Case Management and Coordination of Care.

3) Upon a Member's disenrollment, Contractor shall make the HIF/MET assessment results available to their new Medi-Cal Managed Care Health Plan upon request.

C. Hospice Care

1) Contractor shall cover and ensure the provision of hospice care services as defined in Sections 1905(o)(1) of the Social Security Act. Contractor shall ensure that Members and their families are fully informed of the availability of hospice care as a covered service and the methods by which they may elect to receive these services. Services shall be limited to individuals who have been certified as terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course, and who directly or through their representative voluntarily elect to receive such benefits in lieu of other care as specified. However, for a member under

age 21, a voluntary election of hospice care shall not constitute a waiver of any rights of that member to be provided with, or to have payment made for covered services that are related to the treatment of that member's condition for which a diagnosis of terminal illness has been made.

For individuals who have elected hospice care, Contractor shall arrange for continuity of medical care, including maintaining established patient-Provider relationships, to the greatest extent possible. Contractor shall cover the cost of all hospice care provided. Contractor is also responsible for all medical care not related to the terminal condition.

2) Admission to a nursing facility of a Member who has elected covered hospice services, as described in Title 22 CCR Section 51349, does not affect the Member's eligibility for enrollment under this Contract. Hospice services are Covered Services under this Contract and are not Long-Term Care (LTC) services regardless of the Member's expected or actual length of stay in a nursing facility.

D. Vision Care - Lenses

Contractor shall cover and ensure the provision of eye examinations and prescriptions for corrective lenses as appropriate for all Members **,** ~~, with the exception that~~ Contractor**'s responsibility to** ~~shall~~ arrange for the fabrication of optical lenses for Members through Prison Industry Authority (PIA) optical laboratories **shall be limited to Medi-Cal covered optical/optical lab services**. Contractor shall cover the cost of the eye examination and dispensing of the lenses **fabricated by PIA and specialty lenses, including lenses that exceed PIA ranges** for **qualifying** Members **as described in W & I Code, Section 14131.10**. DHCS will reimburse PIA for the fabrication of the optical lenses in accordance with the contract between DHCS and PIA.

E. Mental Health and Substance Use Disorder Services

1) Contractor shall cover **mild to moderate** Outpatient Mental Health Services that are within the scope of practice of Primary Care Providers and mental health care Providers~~, in~~

~~accordance with the Outpatient Mental Health Services requirements as defined in Exhibit E, Attachment 1, Definitions~~. Contractor's policies and procedures shall define and describe what services are to be provided by Primary Care Providers.

In addition, Contractor shall cover and ensure the provision of psychotherapeutic drugs prescribed by its Primary Care Providers or other mental health care professionals, except those specifically excluded in this Contract as stipulated below.

2) Contractor shall cover and pay for all Medically Necessary **Mental Health** Covered Services for the Member, including the following services:

a) Emergency room professional services as described in Title 22 CCR Section 53855, except services provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, or other specialty mental health Providers.

b) Facility charges for emergency room visits which do not result in a psychiatric admission.

c) All laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition.

d) Emergency Medical Transportation services necessary to provide access to all Medi-Cal Covered Services, including emergency mental health services, as described in Title 22 CCR Section 51323.

e) All NEMT services, as provided for in Title 22 CCR Section 51323, required by Members to access Medi-Cal covered mental health and substance use disorder services. These services include outpatient opioid detoxification, tobacco cessation, and Alcohol Misuse Screening and Counseling (AMSC) services, and are subject to a written prescription by Contractor's mental health or substance use disorder

Provider within Contractor's mental health and substance use disorder Provider Network.

f) Medically Necessary Covered Services after Contractor has been notified by a Specialty Mental Health Provider that a Member has been admitted to an inpatient psychiatric facility, including an Institution for Mental Diseases (IMD) as defined by Title 9 CCR Section 1810.222.1, regardless of the age of the Member. These services include, but are not limited to:

i The initial health history and physical examination required upon admission and any consultations related to Medically Necessary Covered Services.

ii. Notwithstanding this requirement, Contractor shall not be responsible for room and board charges for psychiatric inpatient hospital stays by Members.

iii. When IMD services are provided to Members age 21 and under or age 65 and over, Contractor shall cover Skilled Nursing Facility (SNF) room and board. Contractor shall not cover other inpatient psychiatric facility/IMD room and board charges or other services that are reimbursed as part of the inpatient psychiatric facility/IMD per diem rate.

g) All Medically Necessary Medi-Cal covered psychotherapeutic drugs for Members not otherwise excluded under this Contract.

i. This includes reimbursement for covered psychotherapeutic drugs prescribed by out-of-~~plan~~Network psychiatrists for Members.

ii. Contractor may require that covered prescriptions written by out-of-Network psychiatrists be filled by pharmacies in Contractor's Provider Network.

iii. Reimbursement to pharmacies for those psychotherapeutic drugs listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model, Capitated/Noncapitated Drugs section, which lists excluded psychiatric drugs, shall be reimbursed through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-Network pharmacy Provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program.

h) Paragraphs c), e), and f) above shall not be construed to preclude Contractor from: (1) requiring that Covered Services be provided through Contractor's Provider Network, to the extent possible, or (2) applying utilization review controls for these services, including prior authorization, consistent with Contractor's obligation to provide Covered Services under this Contract.

3) Contractor shall develop and implement a written internal policy and procedure to ensure that Members who need Specialty Mental Health Services (services outside the scope of practice of Primary Care Providers) are referred to and are provided mental health services by an appropriate Medi-Cal FFS mental health Provider or to the county mental health plan for Specialty Mental Health Services in accordance with Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 6. Specialty Mental Health.

4) Contractor shall establish and maintain mechanisms to identify Members who require non-covered psychiatric services and ensure appropriate referrals are made. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the mental health treatment and coordinate services between the Primary Care Provider and the psychiatric service Provider(s). Contractor shall enter into a Memorandum of Understanding with the county mental health plan in accordance with Exhibit A, Attachment 12, Local Health Department Coordination, Provision 3. County Mental Health Plan Coordination.

F. Tuberculosis (TB)

1) TB screening, diagnosis, treatment and follow-up are covered under this Contract. Contractor shall provide TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.

2) Contractor shall coordinate with Local Health Departments in the provision of direct observed therapy as required in Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 16. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB) and Attachment 12, Local Health Department Coordination.

G. Pharmaceutical Services and Provision of Prescribed Drugs

1) Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and Prescription Drugs in accordance with all federal and State laws and regulations including, but not limited to Title 22 CCR Sections 53214 and 53854, Title 16, Sections 1707.1, 1707.2, and 1707.3, 42 CFR 438.3(s), and Sections 1927(d)(5) and 1927(k)(2) of the Social Security Act. Prior authorization requirements for pharmacy services and provision of prescribed drugs must be clearly described in the Member Services Guide and Contractor's provider manual.

2) At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours.

~~Contractor's drug utilization review (DUR) systems should be comparable to such programs administered by the State, and are subject to requirements outlined in 42 CFR 438.3(s), Section 1927(g) of the Social Security Act, and 42 CFR 456, subpart K.~~

3) Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation. Contractor shall meet this requirement by doing all of the following:

a) Having written policies and procedures, including, if applicable, written policies and procedures of Contractor's Network hospitals' policies and procedures related to emergency medication dispensing, which describe the method(s) that are used to ensure that the emergency medication dispensing requirements are met, including, if applicable, specific language in Network hospital subcontracts. Written policies and procedures must describe how Contractor and/or Contractor's Network hospitals will monitor compliance with the requirements. Compliance monitoring does not require verification of receipt of medications for each and every ER visit made by Members to an emergency room which does not result in hospitalization.

b) Providing the Member, in all cases, access to at least a 72-hour supply of Medically Necessary drugs. This requirement can be met by providing a 72-hour supply of the drug to the Member, or provision of an initial dose of medication and a prescription for additional medication, which together cover the Member for the 72-hour period. Contractor's policies and procedures can describe other methods for ensuring compliance with the 72-hour requirement.

c) Having a mechanism in place for informing Members of this requirement and of their right to submit a Grievance if they do not receive Medically Necessary medications in emergency situations.

d) Having a procedure for investigating and resolving Grievances related to the failure of Contractor to provide Medically Necessary medications in emergency situations.

e) Having policies and procedures and Grievance and Appeal logs available for inspection during any State audit or monitoring visit, upon request.

4) Continuity of Care

Contractor must maintain policies and procedures outlining continuity of care in compliance with the provisions of

Welfare and Institutions Code 14185(b), and Health and Safety Code 1367.22. All newly enrolled Members shall be maintained on their current drug therapy, including non-formulary drugs without Prior Authorization until the Member is evaluated or re-evaluated by a Network Provider.

5) Formulary Requirements

Contractor shall post current formulary drug lists on Contractor's website in a machine readable file and format, and make a printed version available to Members upon request pursuant to 42 CFR 438.10(i). Contractor's drug formulary must meet the following requirements:

a) Contractor shall submit to DHCS a complete formulary for review and approval, prior to use. Contractor shall also submit an annual formulary to DHCS for review and approval. Contractor may use the formulary as published until DHCS notifies ~~the~~ Contractor of approval or of required changes. In addition to the annual formulary submission, Contractor shall submit any changes to its formulary to DHCS as File and Use. DHCS may request an updated or current formulary at any time.

b) Contractor's formulary shall be comparable to the Medi-Cal FFS contract drugs list (CDL), except for drugs carved out through specific contract agreements. Comparable means that:

i. Every therapeutic category or class listed on the Medi-Cal FFS CDL shall be represented by at least one (1) drug on Contractor's formulary within six (6) months of its inclusion. Therapeutic category or class is defined by the American Hospital Formulary Service pharmacologic therapeutic classification system to include all tiers of United States Pharmacopeia.

ii. If Contractor places Prior Authorization requirements on all drugs within the same therapeutic category, and one (1) such drug is available on the Medi-Cal FFS CDL without treatment authorization request requirements,

Contractor shall submit the following for all drugs of that same mechanism of action:

a. Clinical rationale for such an action.

b. Criteria used to decide on the Prior Authorization request and/or how the approval criteria for the formulary option(s) differs from the non-formulary options.

iii. A drug not listed on the formulary must be available by Prior Authorization if deemed Medically Necessary.

iv. All drugs listed on the Medi-Cal FFS list need not be included in Contractor's formulary.

6) Contractor shall implement and maintain a process to ensure that its formulary is reviewed and updated no less than quarterly by Contractor's PTC. The PTC must include the following:

a) A majority of members who are practicing Physicians and/or practicing pharmacists;

b) Contractor's Pharmacist as a voting member;

c) At least one (1) practicing Physician and at least one (1) practicing pharmacist who are independent and free of conflict of interest from pharmaceutical manufacturers; and

d) At least one (1) practicing Physician and one (1) practicing pharmacist who are experts regarding care of elderly or disabled Members.

This review and update of Contractor's formulary must consider all drugs approved by the FDA and/or added to the Medi-Cal FFS CDL. Deletions to the formulary must be documented and justified.

7) Drug Utilization Review (DUR)

Contractor shall develop and implement effective DURs and treatment outcome processes as directed in APL 17-008 **and APL 19-012,** to ~~assure~~ **ensure** that drug utilization is appropriate, Medically Necessary, and not likely to result in adverse events.

a) Contractor's DURs **should be comparable to such programs administered by the State,** must meet or exceed the requirements described in **42 CFR 438.3(s),** Section 1927(g) of the Social Security Act**,** ~~and~~ 42 CFR 456, Subpart K**, and Section 1004 requirements of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patient and Communities Act, and implement:**

i. Safety edit on the prescription's days' supply, early refills, duplicate fills, and quantity limitations on opioids and a claims review automated process that indicates the number of fills of opioids in excess of limitations identified by the Department;

ii. Safety edits on the maximum daily morphine equivalent for treatment of pain, and a claims review automated process that indicates when a Member is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the Department;

iii. A claims review automated process that monitors when a Member is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;

iv. A program to monitor and manage the appropriate use of antipsychotic medications by all children 18 years of age and under including foster children enrolled under the California Medicaid State Plan;

v. Fraud and abuse identification processes for potential fraud or abuse of controlled

substances by Members, Providers, and pharmacies;

b) Contractor shall annually submit to DHCS a detailed report in a format specified by DHCS on their DUR Program activities.

c) Contractor's process should also ensure that DURs are appropriately conducted and that pharmacy service and drug utilization Encounter Data are provided to DHCS on a monthly basis.

XII. Exhibit A, Attachment 11, CASE MANAGEMENT AND COORDINATION OF CARE, is amended to read:

9. California Children's Services (CCS)

Services provided by the CCS program are not covered under this Contract. Upon adequate diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS-eligible condition, Contractor shall refer the Member to the local CCS office for determination of eligibility.

A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited, to those which:

1) Ensure that Contractor's Providers perform appropriate baseline health assessments and diagnostic evaluations which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-eligible medical condition;

2) Assure that contracting Providers understand that CCS reimburses only CCS-paneled Providers and CCS-approved hospitals within Contractor's Network; and only from the date of referral;

3) Enable initial referrals of Member's with CCS-eligible conditions to be made to the local CCS program by telephone, same-day mail or fax, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.

4) Ensure that Contractor continues to provide all Medically Necessary Covered Services to the Member until CCS eligibility is confirmed.

5) Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all Medically Necessary Covered Services that are not authorized by CCS and shall ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty **P**roviders, and the local CCS program. **Contractor shall continue to provide case management services to ensure all Medically Necessary treatment authorized through the CCS program is timely provided as required in Exhibit A, Attachment 10, Scope of Services, Provision 5. Services for Members under Twenty-One (21) Years of Age. Without limitation, Contractor shall, as necessary, or upon a Member's request, arrange for all in-home nursing hours authorized by the CCS program that a Member desires to utilize, as required by APL 20-012.**

6) If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member. If the local CCS program denies authorization for any service, Contractor remains responsible for obtaining the service, if it is Medically Necessary, and paying for the service if it has been provided.

B. Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of CCS services to Members.

C. The CCS program authorizes Medi-Cal payments to Contractor Network physicians who currently are members of the CCS panel and to other Providers who provided CCS-covered services to the Member during the CCS-eligibility determination period who are determined to meet the CCS standards for paneling. Contractor shall inform Providers, except as noted above, that CCS reimburses only CCS paneled Providers. Contractor shall submit information to the CCS program on all Providers who have provided services to a Member thought to have a CCS-eligible condition.

Authorization for payment shall be retroactive to the date the CCS program was informed about the Member through an initial referral by Contractor or a Contractor Network physician, via telephone, fax, or mail. In an emergency admission, Contractor or Contractor Network physician shall be allowed until the next Working day to inform the CCS program about the Member. Authorization shall be issued upon confirmation of panel status or completion of the process described above.

XIII. Exhibit A, Attachment 13, MEMBER SERVICES, is amended to read:

~~**3. Call Center Reports**~~

~~Contractor shall report quarterly, in a format to be approved by DHCS, the number of calls received by call type (questions, Grievance and Appeals, access to services, request for health education, etc.); the average speed to answer Member services telephone calls with a live voice; and the Member services telephone calls abandonment rate.~~

~~4~~ 3. Written Member Information

A. Contractor shall provide all new Medi-Cal Members, and Potential Enrollees upon request only, with Member information as specified in Title 22 CCR Section 53895 and as stated in this Provision. Compliance with items required by Section 53895(b) may be met through distribution of the Member Services Guide.

The Member Services Guide shall meet the requirements of an enrollee handbook in 42 CFR 438.10(g), and an Evidence of Coverage and Disclosure Form (EOC/DF) as stipulated by Title 28, CCR, Sections 1300.51(d), Exhibit T (EOC) or U (Combined EOC/DF) and Title 22 CCR Section 53881. In addition, the Member Services Guide shall meet the requirements contained in 42 CFR 438.10(d), and Health and Safety Code, Section 1363, as to print size, readability, and understandability of text.

B. Contractor shall provide the Member information no later than seven (7) calendar days after the effective date of the Member's enrollment. Contractor shall revise this information, if necessary, and distribute it annually to each Member or family unit. To provide Member information in any format other than as printed materials, including but not limited to in electronic format or upon request,

Contractor must submit their process to DHCS for review and approval before implementing.

C. Contractor shall ensure that all Member information is provided to Members at a sixth grade reading level or as determined appropriate through Contractor's ~~GNA~~ **PNA** and approved by DHCS. Member information shall ensure Members' understanding of Contractor's processes and the Member's ability to make informed health decisions.

D. Member information shall include the Member Services Guide, provider directory, significant mailings and notices, and any notices related to Grievances, actions, and Appeals. All Member information shall be in a format that is easily understood and in a font size no smaller than 12-point, pursuant to 42 CFR 438.10.

1) Member~~-~~ information shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, Provision 13, Linguistic Services.

2) Member information shall be provided in alternative formats (including Braille, large-size print font no smaller than ~~18~~ **20**-point, **accessible electronic format,** or audio format) and through Auxiliary Aids at no cost, upon request, and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of Members with disabilities or LEP.

3) Contractor shall establish policies and procedures to enable Members to make a standing request to receive all Member information in a specified threshold language or alternative format.

4) ~~Member information shall include taglines and information on how to request Auxiliary Aids and services, including materials in alternative formats, in large print font no smaller than 18-point, and in all State threshold languages as required in this Provision. The taglines shall explain the availability of written Member information translated in that language or oral interpretation to understand the information provided, and the toll-free and TTY/TDD telephone number for Contractor's Member services~~. **Contractor shall post (1) a DHCS-approved nondiscrimination notice, (2) language taglines in the threshold languages and at**

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least the top 16 non-English languages in the State, as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and (3) a large print tagline in no smaller than 18-point font, explaining how to request free language assistance services and Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and taglines shall include Contractor's toll-free and TTY/TDD telephone number for obtaining these services, and shall be posted as follows:

a) In all conspicuous physical locations where Contractor interacts with the public;

b) In a conspicuous location on Contractor's website that is accessible on the Contractor's home page, and in a manner that allows Members, Potential Enrollees, and members of the public to easily locate the information; and

c) In all Member information, and in all other significant communications and significant publications targeted to Members, Potential Enrollees, applicants, and members of the public, except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures. (42 CFR section 438.10(d)(2)-(3); 45 CFR section 92.8(d)(1), (f)(1)(i)-(iii); W&I Code, section 14029.91(f)).

5) Contractor shall post (1) a DHCS-approved nondiscrimination statement and (2) language taglines in at least the top two non-English languages in the State (as determined by DHCS), explaining the availability of free language assistance services, and the toll-free and TTY/TDD telephone number for obtaining these services, and (3) a large print tagline in no smaller than 18-point font, explaining how to request free language assistance services and Auxiliary Aids and services, including materials in alternative formats, as follows:

a) In all significant publications and significant communications that are small-sized, such as

postcards and tri-fold brochures. (42 CFR section 438.10(d)(2)-(3); 45 CFR section 92.8(d)(2), (g)).

6) Contractor's nondiscrimination notice shall include all information required by W&I Code section 14029.91(e), 45 CFR section 92.8, any additional information required by DHCS, and shall provide information on how to file a discrimination Grievance with:

a) Both Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56.

b) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (45 CFR section 92.8(a)(7); W&I Code section 14029.91(e)).

E. Provider Directory

1) Contractor shall furnish its Medi-Cal provider directory to all Members and make available to DHCS for distribution as needed.

2) Contractor's provider directory shall be made available in both a paper and electronic form. Provider directory information shall be included with Contractor's written Member information for new Members, and thereafter available upon request. Electronic provider directories shall be posted on Contractor's web site in a machine readable file and format.

3) Contractor shall submit a complete provider directory to DHCS for review and approval prior to initial operations.

4) Contractor shall update its paper and electronic provider directories in accordance with 42 CFR 438.10(h)(3) and

submit updated complete directories to DHCS as File and Use. DHCS may ask for changes at any time.

5) Contractor's provider directory is reviewed every six (6) months by DHCS. Findings shall be addressed immediately by Contractor.

6) Provider directories shall be compliant with 42 CFR 438.10(h) and Health and Safety Code 1367.27, and shall include the following information for PCPs, Specialists, hospitals, pharmacies, behavioral health Providers, MLTSS Providers as appropriate, and any other Providers contracted for Medi-Cal Covered Services:

   a) The Provider or site's name and any group affiliation, NPI number, address, telephone number, and, if applicable, web site URL for each service location, and Provider specialty as appropriate;

   b) For a medical group/foundation or IPAs, the medical group/foundation or IPA name, NPI number, address, telephone number, and, if applicable, web site URL shall appear for each Physician Provider;

   c) The hours and days when each service location is open;

   d) The services and benefits available, including accessibility symbols approved by DHCS and whether the office/facility (exam room(s), equipment, etc.) can accommodate Members with physical disabilities;

   e) The Provider's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the Provider or a skilled medical interpreter at the Provider's facility, and if the Provider has completed cultural competence training;

   f) The telephone number to call after normal business hours; and

   g) Identification of Providers or sites that are not available to all or new Members.

F. Contractor shall provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of, and the right to obtain, available and accessible covered health care services. DHCS shall provide Contractor with a template for the Member Services Guide prior to distribution to Members. Contractor shall submit a complete Member Services Guide to DHCS for review and approval prior to implementing. Contractor shall ensure that the Member Services Guide includes the following information:

1) The plan name, address, toll-free telephone number(s) for Member services and any other Contractor staff providing services directly to Members, and service area covered by the health plan.

2) A description of the full amount, duration, and scope of Medi-Cal Managed Care covered benefits and all available services including health education, interpretive services provided by Contractor's personnel and at service sites, and an explanation of "carve out" services and any service limitations and exclusions from coverage or charges for services. Include information and identification of services to which the Contractor or Subcontractor has a moral objection to perform or support.

3) Procedures for accessing Covered Services which explain that Covered Services shall be obtained through Contractor's Providers unless otherwise allowed under this Contract, and the process for Members selecting and changing their PCP. Include any applicable Subcontractor arrangements that may restrict access.

4) A description of the Member identification card issued by the Contractor, if applicable, and an explanation as to its use in authorizing or assisting Members to obtain services.

5) Procedures for selecting or requesting a change in PCP at any time; any requirements that a Member would have to change PCP; reasons for which a request for a specific PCP may be denied; and reasons why a Provider may request a change.

6) The purpose and value of scheduling an IHA appointment.

7) The appropriate use of health care services in a managed care system.

8) The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate Provider locations and telephone numbers. This shall include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after hours services.

9) Definition of what constitutes an emergency medical condition, emergency health care and post-stabilization services, in accordance with 42 CFR 438.10(g)(2)(v), and that prior authorization is not required to receive emergency services. Include the use of 911 for obtaining emergency services.

10) The right to receive emergency health care in any hospital or other setting, including at least a 72-hour supply of Medically Necessary medication in an emergency situation. Also include procedures for obtaining emergency health care from specified Network Providers or from Out-of-Network Providers, including outside of Contractor's Service Area.

11) Process for referral to Specialists in sufficient detail so **the** Member can understand how the process works, including timeframes **and alternative access standards as required by W&I Code 14197.04 and APL 20-003** .

12) Procedures for obtaining any transportation services to service sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of both medical transportation and NMT services and the conditions under transportation is available.

13) The right, and procedures, to file a Grievance and request an Appeal with Contractor, either orally, ~~or~~ in writing, or over the phone, including procedures to Appeal decisions that deny, delay or modify a Member's request for services. Include the toll-free telephone number a Member can use to file a Grievance or request an Appeal, and the title, address,

and telephone number of the person responsible for processing and resolving Grievances and Appeals and providing assistance completing the request. Information regarding the process shall include the requirements for timeframes to file a Grievance or request an Appeal, notification that an oral request for an Appeal of an action should be followed by a written request for an Appeal, and timelines for ~~the~~ Contractor to acknowledge receipt of Grievances and Appeals, to resolve Grievances and Appeals, and to notify the Member of the resolution of Grievances or Appeals. Contractor shall inform the Member that services previously authorized by Contractor will continue while the Appeal is being resolved.

14) The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Exhibit A, Attachment 16, Provision 3, Disenrollment.

15) Procedures for disenrollment, including an explanation of the Member's right to disenroll ~~without cause~~ at any time, **and reenroll in the competing plan in the county (in counties where another Medi-Cal Managed Care Health Plan is available), subject to the requirements in 22 CCR 53891(c) and** ~~subject to~~ any restricted disenrollment period.

16) Information on the Member's right to the Medi-Cal State Fair Hearing process, the method for obtaining a Hearing, the timeframe to request a Hearing, and the rules that govern representation in a Hearing. Include information on the circumstances under which an expedited State Fair Hearing is possible and information regarding assistance in completing the request pursuant to Title 22 CCR Section 53452, when a health care service requested by the Member or Provider has been denied, deferred or modified. Information on State Fair Hearings shall also include information on the timelines which govern a Member's right to a State Fair Hearing, pursuant to Welfare and Institutions Code Section §10951 and the State of California Department of Social Services' Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253) to request a State Fair Hearing. Information shall include that services previously authorized by the Contractor will continue while the State Fair Hearing is being resolved if the Member requests a Hearing in the specified timeframe.

17) Information on the availability of, and procedures for obtaining, services at FQHCs and American Indian Health Service Programs.

18) Information on the Member's right to seek family planning services from any qualified Provider of family planning services under the Medi-Cal program, including Providers outside Contractor's Provider Network, how to access these services, that a referral is not necessary, and a description of the limitations on the services that Members may seek outside the plan. Contractor may use the following statement:

Family planning services are provided to Members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN Specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name (Contractor)] without having to get permission from [Plan Name (Contractor)]. [Plan Name (Contractor)] shall pay that doctor or clinic for the family planning services you get.

19) Procedures for providing female Members with direct access to a women's health Specialist within the Network for covered care necessary to provide women's routine and preventive health care
services. This is in addition to the Member's designated source of primary care if that source is not a woman's health Specialist.

20) The Department of Social Services (DSS) Office of Family Planning toll-free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics.

21) Information on the availability of, and procedures for obtaining, Certified Nurse Midwife and Certified Nurse Practitioner services, pursuant to Exhibit A, Attachment 9, Provision 7. Nurse Midwife and Nurse Practitioner Services.

22) Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information with all Member Service Guides sent to Members after the date such information is furnished to Contractor by DHCS.

23) Information on how to access State resources for investigation and resolution of Member complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609), and the DMHC, Health Maintenance Organization (HMO) Consumer Service toll-free telephone number (1-800-400-0815).

24) Information concerning the provision and availability of services covered under the CCS program from Providers outside Contractor's Provider Network and how to access these services.

25) An explanation of the expedited disenrollment process for Members qualifying under conditions specified under Title 22 CCR Section 53889(j), which includes children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health care needs, including, but not limited to major organ transplants; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.

26) Information on how to obtain Minor Consent Services through Contractor's Provider Network, an explanation of those services, and information on how they can also be obtained out of the Contractor’s Provider Network.

27) An explanation on how to use the FFS system when Medi-Cal Covered Services are excluded or limited under this Contract and how to obtain additional information.

28) An explanation of an American Indian Member's right to not enroll in a Medi-Cal Managed Care plan, to be able to access American Indian Health Service Programs, to choose an American Indian Health Care Provider within Contractor’s Network as a Primary Care Provider, and to disenroll from Contractor's plan at any time, without cause.

29) A notice regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor. Pursuant to California Health and Safety Code Section 7158.2, this notice must be provided upon enrollment and annually thereafter in the evidence of coverage (Member Services Guide), health plan newsletter or any other direct communication with Members.

30) A statement as to whether the Contractor uses Provider financial bonuses or other incentives with its contracting Providers of health care services and that the Member may request additional information about these bonuses or incentives from the plan, the Member's Provider or the Provider's medical group or independent practice association, pursuant to California Health and Safety Code, Section 1367.10.

31) Contractor's drug formulary information notice. Pursuant to California Health and Safety Code, Section 1363.01, and 42 CFR 438.10(d)(6) and (i), the drug formulary information notice shall: (1) be in ~~the~~ an easily understood language; (2) include an explanation of what a formulary is, which medications are covered, both generic and name brand, what tier each medication is on, how the plan decides which Prescription Drugs are included or excluded from the formulary, and how often the formulary is updated; (3) indicate that the drug formulary is available on Contractor's website in a machine readable file, available in a hard copy, and provide the telephone number for requesting this information; and (4) indicate that the presence of a drug on the plan's formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing Provider for a particular medical condition.

32) Policies and procedures regarding a Members' right to formulate advance directives. This information shall include the Member's right to be informed by the Contractor of State law regarding advance directives, and to receive information from the Contractor regarding any changes to that law. The information shall reflect changes in State law regarding advance directives as soon as possible, but no later than 90 calendar days after the effective date of change.

33) Instructions on how a Member can view online, or request a copy of, Contractor's non-proprietary clinical and administrative policies and procedures.

34) That oral interpreter services are available for any language spoken by the Member, and written translations of Member materials are available in the identified threshold languages, both free of charge, with instruction on how to access these services.

35) That Auxiliary Aids and services are available upon request and at no cost for Members with disabilities, and how to access these services. Include taglines in large-size print font no smaller than 18-point, on how to request Auxiliary Aids and Member information in alternative formats.

36) Information on how to report suspected fraud or abuse.

37) Any other information determined by DHCS to be essential for the proper receipt of Covered Services.

G. Member Identification Card

Contractor shall provide an identification card to each Member, which identifies the Member and authorizes the provision of Covered Services to the Member. The card shall specify that emergency services rendered to the Member by non-contracting Providers are reimbursable by the Contractor without prior authorization.

~~5~~ 4. Notification of Changes in Access to Covered Services

A. Contractor shall ensure Medi-Cal Members are notified in writing of any changes in the availability or location of Covered Services, or any other changes in information listed in 42 CFR Section 438.10(g), at least 30 calendar days prior to the effective date of such changes. In the event of an emergency or other unforeseeable circumstances, Contractor shall provide notice of the emergency or other unforeseeable circumstance to DHCS as soon

as possible. The notification must ~~also~~ be presented to and approved in writing by DHCS prior to its~~'~~ release.

B. Pursuant to 42 CFR 438.10(f)(1) Contractor shall make a good faith effort to give written notice of termination of a contracted Provider within 15 calendar days after receipt or issuance of the termination notice to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated Provider. This notification must also be presented to and approved in writing by DHCS prior to its release.

~~6~~ 5. Primary Care Provider Selection

A. Contractor shall implement and maintain DHCS approved procedures to ensure that each new Member has an appropriate and available Primary Care Physician.

1) Contractor shall provide each new Member an opportunity to select a Primary Care Physician within the first 30 calendar days of enrollment.
2) Contractor may allow Members to select a clinic that provides primary care.
3) If the Contractor's Provider Network includes Nurse Practitioners, Certified Nurse Midwives, or Physician Assistants, the Member may select a Nurse Practitioner, Certified Nurse Midwife, or Physician Assistant within 30 calendar days of enrollment to provide Primary Care services in accordance with Title 22 CCR Section 53853(a)(4).
4) Contractor shall provide a mechanism for SPD beneficiaries to select a Specialist or clinic that meets DHCS subcontracting requirements as stated in Attachment 6 of this contract as a Primary Care Physician if the Specialist or clinic agrees to serve as a Primary Care Provider and is qualified to treat the required range of conditions of the SPD beneficiary, per W & I Code Section 14182 (b)(11).
5) Contractor shall ensure that Members are allowed to change a Primary Care Physician, Nurse Practitioner, Certified Nurse Midwife or Physician Assistant, upon request, by selecting a different Primary Care Provider from Contractor's Network.

B. Contractor shall disclose to affected Members any reasons for which their selection or change in Primary Care Physician could not be made.

C. Contractor shall ensure that Members with an established relationship with a Provider in Contractor's Network, who have expressed a desire to continue their patient/Provider relationship, are assigned to that Provider without disruption in their care.

D. Contractor shall ensure that Members may choose Traditional and Safety-Net Providers as their Primary Care Provider, and that American Indian Members may choose an American Indian Health Care Provider within Contractor's Network as their Primary Care Provider.

E. Contractor shall not be obligated to require Full Benefit Dual Eligible Members to select a Medi-Cal Primary Care Provider. Nothing in this section shall be construed to require Contractor to pay for services that would otherwise be paid for by Medicare.

~~7~~ 6. Primary Care Provider Assignment

A. If the Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall assign that Member to a Primary Care Provider and notify the Member and the assigned Primary Care Provider no later than 40 calendar days after the Member's enrollment. Contractor shall ensure that adverse selection does not occur during the assignment process of Members to Providers.

~~B. For Riverside/San Bernardino Counties Only~~

~~If an Adult Expansion Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, and resides in a public hospital system county, as defined in Welfare and Institutions Code Section 17612.2, Subdivision (u), Contractor shall assign the Adult Expansion Member to a Primary Care Provider as follows:~~

~~1) During a three (3) year period, ending on December 31, 2016, Contractor shall assign at least 75 percent of Adult Expansion Members who do not select a Primary Care Provider, to a Primary Care Provider within the county public hospital health system, until the county public hospital health~~

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~~system meets its enrollment target, as defined in Welfare and Institutions Code Section 14199.1(b)(3).~~

~~2) Following the expiration of the three (3) year period as stated above, Contractor shall assign at least 50 percent of Adult Expansion Members who do not select a Primary Care Provider to a Primary Care Provider within the county public hospital health system until the county public hospital health system meets its applicable enrollment target.~~

~~3) The above two paragraphs shall not apply with respect to a county public hospital health system during any time period in which the county public hospital health system meets or exceeds its applicable enrollment target. For these time periods, Adult Expansion Members shall be assigned to Primary Care Providers in the same manner as other Members who do not affirmatively select a Primary Care Provider. A county public hospital health system can notify Contractor that it has reached its maximum capacity for the assignment of Adult Expansion Members.~~

~~4) If at any time the county public hospital health system notifies Contractor that it again has capacity to accept assignment of Adult Expansion Members, the requirements set forth in Paragraphs 1) and 2) shall apply, effective on the first day of the month following that notice.~~

~~5) In implementing the requirements contained in this Provision, Contractor shall first assign Adult Expansion Members to a Primary Care Provider within the county public hospital health system from whom the Adult Expansion Member has accessed care two or more times within the past 12 months, if the Contractor is appropriately notified by DHCS of the prior existing relationship.~~

~~a) Contractor shall use utilization data or other data sources, including electronic data, as provided by DHCS to establish existing Provider relationships with county public hospital health system Providers for the purpose of Primary Care Provider assignment.~~

~~b) DHCS shall work with the county public hospital health systems to gather and provide this data to Contractor.~~

~~6) Contractor shall not assign Adult Expansion Members to a Primary Care Provider within the county public hospital health system if that Primary Care Provider has notified Contractor that it does not have capacity to accept new Adult Expansion Members.~~

~~7) The assignment process described in this Provision shall not apply to LIHP Members subject to Welfare and Institutions Code Section 14005.60.~~

~~8) Nothing set forth in this Provision shall alter, reduce, or modify in any manner the way Contractor assigns other Members to the county public hospital health systems.~~

~~9) Nothing in this Provision shall modify the ability of Adult Expansion Members from selecting or changing their Primary Care Providers.~~

~~10) If the Contractor identifies a concern regarding patient quality or access (through mechanisms such as Grievances, Member satisfaction, secret shopper-Provider surveys, etc.) within the county public hospital health system (PHHS), Contractor may cease default enrollment into the PHHS upon approval from DHCS and until such time as the issue has been satisfactorily addressed.~~

~~C~~ **B**. If a Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall use utilization data or other data sources provided by DHCS, including electronic data, to establish existing Provider relationships for the purpose of Primary Care Provider assignment, including a Specialist or clinic for a SPD beneficiary if a preference for either has been indicated. Contractor shall comply with all federal and State privacy laws in the provision and use of this data.

~~D~~ **C**. Contractor shall notify the Primary Care Provider that a Member has selected or been assigned to the Provider within ten (10) calendar days from when selection or assignment is completed by the Member or the Contractor, respectively.

~~E~~ **D**. Contractor shall maintain procedures that proportionately include contracting Traditional and Safety-Net Providers in the assignment process for Members who do not choose a Primary Care Provider.

~~F~~ **E**. Contractor shall not be required to assign Members who are eligible for services through Medicare to a Medi-Cal Primary Care Provider except as specified in APL 14-015. Nothing in this section shall be construed to require health plans to pay for services that would otherwise be paid for by Medicare.

~~G~~ **F**. Contractor shall provide any Member utilization data received from DHCS to the Primary Care Provider or Subcontractor to which a Member has been assigned for the coordinating the Members care. To the extent the Provider is not equipped to receive the data, Contractor shall make it available to the Primary Care Provider or Subcontractor.

~~8~~ 7. Denial, Deferral, or Modification of Prior Authorization Requests

A. Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with 42 CFR 438.210(c) and Title 22 CCR Sections 51014.1 and 53894 by providing a NOA to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in 42 CFR 438.404, Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01. **Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the decision is made, not to exceed 14 calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified as explained in Exhibit A, Attachment 5, Provision 3, Contractor shall notify the Member in writing of the deferral of the decision no later than 14 calendar days from the receipt of the original request. If the final decision is to deny or modify the request, Contractor shall provide a written notification of the decision to Members no later than 28 calendar days from the receipt of the original request.**

If the decision regarding a prior authorization request is not made within the time frames indicated in Exhibit A, Attachment 5, Provision 3, the decision is considered denied and notice of the denial must be sent to the Member on the date the time frame expires.

B. Contractor shall ensure that at least ten (10) days of advanced notice is given to a Member when a NOA results in a termination, suspension, or reduction of previously authorized covered services. ~~The~~ Contractor ~~shall~~ **must** shorten the advanced notice to five (5) days if ~~fraud~~ probable recipient fraud has been verified.

Contractor shall not be required to provide advanced notice of a termination, suspension, reduction of services, or reduction of previously authorized covered services when the following conditions apply:

1) Death of a Member;

2) Member provides a written statement requesting service termination or giving information requiring termination or reduction of services;

3) Member admission into an institution that makes the Member ineligible for further services;

4) Member's address is unknown and mail directed to the Member has no forwarding address;

5) Member has been accepted for Medi-Cal services by another local jurisdiction;

6) Member's Primary Care Physician prescribes a change in the level of medical care;

7) An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or

8) Safety or health of individuals in a facility would be endangered, Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Members urgent medical needs, or Member has not resided in the nursing facility for a minimum of 30 days.

C. Contractor shall provide expedited advanced notice to a Member when Contractor, **Subcontractor** or Primary Care Physician indicates that the standard timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. Contractor shall ensure an expedited

authorization decision and provide an expedited notice as the Member's health condition requires and no later than 72 hours after receipt of the request for services. Upon approval from DHCS, Contractor may extend the 72 hour expedited period to 14 calendar days if the Member requests an extension, or if Contractor justifies a need for additional information and that the extension is in the Member's interest.

D. Contractor shall provide for a written notification to the Member and the Member's representative on a standardized form informing the Member of all the following:

1) The Member's right to, and method of obtaining, a State Fair Hearing to contest **Contractor's** ~~the~~ denial, deferral, **delay** or modification **of a requested service** ~~action and the decision the Contractor has made~~.

2) The Member's right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel, friend or other spokesperson.

3) The name and address of Contractor and the State of California Department of Social Services toll-free telephone number for obtaining information on legal service organizations for representation.

~~E. Contractor shall provide a required notification to Members and their authorized representatives in accordance with the timeframes set forth in Title 22 CCR Sections 51014.1 and 53894. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the decision is made, not to exceed 14 calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified as explained in Exhibit A, Attachment 5, Provision 3, Contractor shall notify the Member in writing of the deferral of the decision no later than 14 calendar days from the receipt of the original request. If the final decision is to deny or modify the request, Contractor shall provide a written notification of the decision to Members no later than 28 calendar days from the receipt of the original request.~~

~~If the decision regarding a prior authorization request is not made within the time frames indicated in Exhibit A, Attachment 5, Provision 3, the decision is considered denied and notice of the~~

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~~denial must be sent to the Member on the date the time frame expires.~~

XIV. Exhibit A, Attachment 14, MEMBER GRIEVANCE AND APPEAL SYSTEM, is amended to read:

1. Member Grievance and Appeal System

Contractor shall have in place a system in accordance with Title 28 CCR, sections 1300.68 and 1300.68.01; Title 22 CCR section 53858; Exhibit A, Attachment 13, Provision 4, Paragraph F(13); and 42 CFR 438.402-424. Contractor shall follow Grievance and Appeal requirements, and use all notice templates included in APL ~~17-006~~ **XX-XXX** . Contractor shall ensure that ~~the following requirements are met through~~ its Grievance and Appeal system **meets the following requirements**:

A. Members, or a Provider or authorized representative acting on behalf of a Member and with the Member's written consent, may file a Grievance or request an Appeal with Contractor either orally or in writing.

B. Ensure timely **written** acknowledgement for each Grievance and request for an Appeal, and provide a notice of resolution to the Member as quickly as the Member's health condition requires, **not to exceed** ~~within~~ 30 calendar days from the date Contractor receives the **oral request for a** Grievance or **oral** request for an Appeal. Contractor shall notify the Member, **a Provider, or authorized representative acting on behalf of a Member and with the Member's written consent** of the resolution in a written Member notice.

C. For Members accessing the Grievance and Appeal system, ensure that **Members are given** ~~reasonable~~ assistance ~~is given in~~ **when** completing **Grievance and Appeal** forms and other procedural steps**. This**~~, which~~ includes but is not limited to, providing **all documents relied on for Contractor's decision to the Member, and providing** Auxiliary Aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability.

D. Ensure that the person making the final decision for the proposed resolution of Grievances ~~and~~ **or** Appeals has neither participated in any prior decisions related to the Grievance or Appeal, nor is a subordinate of someone who has participated in a prior decision**.**

Contractor shall ensure that the person making a decision has~~,~~ ~~and has~~ clinical expertise in treating a Member's condition or disease if deciding on any of the following:

1) An Appeal of a denial based on lack of Medical Necessity **or that the service is experimental/investigational**;

2) A Grievance regarding denial of an expedited resolution of an Appeal; and

3) Any Grievance or Appeal involving clinical issues.

E. **Consider** ~~Take into account~~ all comments, documents, records, and other information submitted by the Member or their representative, **regardless of** ~~without regard to~~ whether such information was submitted or considered **during the initial review** ~~in the initial action~~.

F. Ensure that Members are given a reasonable opportunity to present to Contractor evidence and testimony, and make legal or factual arguments, in person as well as in writing, in support of their Grievance or Appeal. Contactor shall inform Members of the limited time available to present evidence sufficiently in advance of the resolution timeframes specified in this Contract, including for expedited Appeals.

G. Notice of resolutions for Grievances and Appeals shall be in a format and language that, at a minimum, meets the standards set forth in 42 CFR 438.10 and Exhibit A, Attachment 13, Provision 4 **Paragraph D**, Member Services, of this Contract. **Contractor must ensure that Language Assistance Taglines and a Nondiscrimination Notice meeting the minimum requirements of provided with APL 20-015 accompanies each member notification, and that the Nondiscrimination Notice is made available, upon request or as otherwise required by law, in any of the threshold languages or in an ADA-compliant, accessible format.**

H. Provide oral notice of the resolution of an expedited **Appeal** ~~review~~ within 72 hours.

I. Provide its Grievance and Appeal system requirements to Subcontractors at the time that they enter into a Subcontract **and**

ensure they are informed of any new requirements in a timely manner.

J. Compile the systematic aggregation and analysis of Grievance and Appeal data and use for Quality Improvement. **Contractor shall continually evaluate and analyze Grievance and Appeal data to identify systemic patterns of improper service denials and other trends impacting health care delivery to Members.**

2. Grievance Process

Contractor shall implement and maintain procedures as described below for Grievances and the expedited review of Grievances required under 42 CFR 438.402, **438.**406, and **438.**408~~,~~**;** Title 28, CCR, ~~Sections~~ **sections** 1300.68 and 1300.68.01~~,~~**;** and Title 22 CCR Section 53858.

A. Procedure to ensure a Member may file a Grievance with Contractor at any time to express dissatisfaction about any matter other than an action resulting in a NOA.

B. Procedure to allow Members to file a Grievance when they disagree with Contractor's decision to extend the timeframe for resolution of an Appeal or expedited Appeal.

C. Procedure to ensure that every Grievance submitted is reported to ~~an~~ **the** appropriate level, i.e., quality of care versus quality of service.

D. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to Contractor's medical director.

E. Contractor shall provide written acknowledgement within five (5) calendar days of receipt of the Grievance. The acknowledgement letter shall advise the Member that the Grievance has been received, the date of the receipt, and provide the name, telephone number, and address of the representative who may be contacted about the Grievance.

3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report

A. Contractor shall accurately maintain and make accessible to DHCS, and have available for CMS upon request, Grievance and Appeal logs, including copies of Grievance and Appeal logs of any

subcontracting entity delegated the responsibility to maintain and resolve Grievances. Grievance and Appeal logs shall include all the required information set forth in Title 22 CCR Section 53858(e). ~~Contractor shall also apply the information requirements for Grievance logs to the inclusion of Appeal.~~

B. **The report shall include Grievances and Appeals handled by Subcontractors. Contractor shall ensure that all documents generated or obtained by Contractor in the course of responding to Adverse Benefit Determinations, Grievances, Appeals, and Independent Medical Reviews are retained for at least 10 years pursuant to 42 CFR 438.3(u).**

~~B~~ **C.** Contractor shall submit a ~~quarterly~~ **monthly** Grievance and Appeal report for Medi-Cal Members only in the form that is required by and submitted to ~~the~~ DMHC**,** as set forth in Title 28~~,~~ CCR~~,~~ Section 1300.68(f), with additional information required by DHCS per 42 CFR 438.416 **and 22 CCR section 53858(e)**.

1) In addition to the types or nature of Grievances listed in Title 28 CCR Section 1300.68(f)(2)(D), the report shall also include, but not be limited to, timely assignments to ~~a~~ **Primary Care** Provider**s**, issues related to **accommodating** cultural and linguistic **sensitivities**, difficulty with accessing Specialists, and Grievances related to Contractor's denial of ~~requests for~~ out-of-Network requests.

2) For the Medi-Cal category of the report, Contractor shall provide the following additional information on both Grievances and Appeals:

   a) The date Contractor received the Grievance or Appeal;

   b) A general description of the reason for the Grievance or Appeal;

   c) The date(s) of Contractor's review of the Grievance or Appeal, or if applicable, a review meeting;

   d) The resolution and date of resolution, at each level of the Grievance or Appeal;

e) The name of the Member ~~for whom~~ **who requested the** review of a Grievance or Appeal ~~was requested~~;

f) The timeliness of responding to the Member; and

g) The geographic region, ethnicity, gender, and primary language of the Member.

~~C~~ **D**. Contractor shall submit **complete, accurate, reasonable, and timely** ~~the quarterly~~ Grievance and Appeal **data within ten (10) calendar days following the end of each month under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall certify all Network data as set forth in 42 CFR 438.606.** ~~report for Medi-Cal Members the following quarters: April – June, July – September, October – December, January – March. The report is due 30 calendar days from the date of the end of the reporting quarter.~~

4. Notice of Action (NOA)

A. A NOA is a formal letter, in a format approved by DHCS, informing a Member of any of the following actions taken by Contractor and sent within the corresponding timeframes:

1) For the denial**, delay, modification,** or limited authorization of a requested Covered Service, send within five (5) business days from receipt of the information reasonably necessary to render a decision, with a possible extension of up to 14 additional calendar days if the Member requests an extension, or if Contractor justifies to DHCS a need for additional information and how the extension is in the Member's interest.

2) For the reduction, suspension, or termination of a previously authorized Covered Service, send with **ten calendar days advance written notice to ensure the Member has time to request continuation of the disputed service until Appeal rights have been exhausted or there is a final hearing decision on the Appeal as required by 42 CFR 438.420** ~~in the timeframes stated in Exhibit A, Attachment 13, Provision 8, Paragraph B~~.

3) For a denial, in whole or in part, of payment for a Covered Service, send at the time of any action affecting the claim.

~~4) For the failure to authorize Covered Services in a timely manner, send on the date that the timeframe expires~~

~~5~~ **4**) For the decision to extend the time frame to authorize a Covered Service and provide information on filing a Grievance if the Member disagrees **with the extension**, send **as expeditiously as the Member's health requires but no later than** 14 calendar days following receipt of the **service** request.

~~6~~ **5**) For an expedited service authorization decision, send within 72 hours of receipt of the request.

B. A written NOA shall be in a format and language that, at a minimum, meets the standards set forth in **42 CFR 438.10 and** Exhibit A, Attachment 13, Provision 4, **Paragraph D**, **Member Services,** and ~~must~~ **shall** include all of the following:

1) ~~The~~ **A clear and concise explanation of the** action that Contractor or its Subcontractor has taken or intends to take~~;~~**,** **including where requested**, **a fully translated written notice, including a translated clinical rationale, within 30 calendar days. In cases where Contractor provides an initial partially translated clinical rationale in the notice, Contractor shall make an affirmative effort to reach Members by telephone to offer verbal translation of the notice and any other assistance the member may need. Contractor is required to make at least three documented attempts to reach the Member by telephone and offer language assistance including verbal translation of notice.**

2) The reason for the action, including notification to the Member of the right to be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and any other information **Contractor or its Subcontractor relied on for the decision** relevant to the action, including **clinical criteria;** ~~the~~ Medical Necessity criteria~~,~~**;** and any processes, strategies, or evidentiary standards used;

3) The Member's right to request an Appeal with Contractor no later than 60 calendar days from the date on the NOA, and information on exhausting Contractor's one-level Appeal system;

4) That an expedited Appeal is available if the Member's health condition requires resolution in less than 72 hours and how to request an expedited Appeal;

4 **5**) The **process for a** Member~~'s right~~ to request a State Fair Hearing after **having exhausted Contractor's internal Appeal process, and having received** ~~requesting an Appeal and receiving~~ notice that Contractor is upholding its action, or **that a Member may request a State Fair Hearing in cases where** ~~after~~ Contractor fails to send a **Notice of Appeal Resolution (NAR)** ~~resolution notice or extension~~ in response to the Appeal within 30 calendar days;

~~5) Procedures for exercising the Member's rights to request an Appeal or a State Fair Hearing;~~

~~6) Circumstances under which an expedited Appeal is available and how to request it;~~

~~7~~ **6**) The Member's right to have Covered Services continue pending the resolution of the Appeal **as required by 42 CFR 438.420**; and the process for **the Member to request continuation of covered services**.

7) **The Member's right to request a review of Contractor's action, called an Independent Medical Review (IMR), from DMHC and that the IMR must be requested before there is a decision on a State Fair Hearing.**

~~8) How to request a continuation of Covered Services.~~

~~C. Once a NOA is sent:~~

~~1) Members have 60 calendar days from the date on the NOA to file request an Appeal of Contractor's action.~~

~~2) Members may request a review of Contractor's action, called an Independent Medical Review (IMR), from the Department of Managed Health Care (DMHC).~~

~~D. Member must be notified that the State must reach its decision for a standard State Fair Hearing within 90 days of the date of the request. For an expedited State Fair Hearing, the State must reach its decision within three (3) working days of receipt of the expedited State Fair Hearing request. Contractor shall also comply with all other requirements as outlined in APL 03-009 and APL 17-006.~~

C. Contractors are not permitted to make any changes to the NOA templates or NOA "Your Rights" attachment without prior review and approval from DHCS, except to insert information specific to members, as required.

5. Appeal Process

Contractor shall have in place a process as ~~described~~ **required** below to resolve Member requests for Appeals. Contractor may have only one level of Appeal for Members. **Upon request, Contractor shall assist Members in preparing their Appeal.**

A. Following the receipt of a NOA, a Member has 60 calendar days from the date on the NOA to file a request for an Appeal either orally or in writing. The Member, or a Provider or authorized representative acting on behalf of a Member and with the Member's written consent, may request an Appeal. Unless the Member is requesting an expedited Appeal, an oral request for an Appeal should be followed by a written and signed Appeal. However, Contractor shall still consider the date the Member made the oral request for an Appeal as the filing date ~~without regard to~~ **regardless of** whether the Member submitted a written request for an Appeal **for purposes of resolving the Appeal within 30 days.**

B. If Contractor fails to send a Member resolution notice within 30 calendar days, **or fails to comply with the notice requirements of 42 CFR 438.10,** the Member is deemed to have exhausted Contractor's internal Appeal process and ~~can~~ **may** request a State Fair Hearing. **This is referred to as Deemed Exhaustion.**

C. Contractor's NAR, ~~A Member resolution notice,~~ at a minimum, must include the result and date of the Appeal resolution. For

decisions not wholly in the Member's favor, Contractor, at a minimum, must include:

1) Member's right to request a State Fair Hearing;

2) How to request a State Fair Hearing;

3) Right to continue to receive benefits pending a State Fair Hearing;

4) How to request ~~the~~ **a** continuation of benefits, and requirements to file a continuation **request** within ten (10) calendar days of when the NOA was sent, or before the intended effective date of the proposed action; ~~and~~

5) The right to request an IMR or a review of Contractor's decision by DMHC **and that the IMR must be requested before there is a final State Fair Hearing decision; and**

6) The DHCS-approved "Your Rights" Attachment.

~~C~~ **D.** Contractor may extend the timeframe to resolve an Appeal by up to 14 calendar days if the Member requests an extension or Contractor shows that there is a need for additional information**. Contractor shall maintain documentation to demonstrate to the Department, why** ~~and how~~ the delay is in the Member's interest. If the timeframe extension has not been requested by the Member, Contractor shall:

1) Make reasonable efforts to give the Member prompt oral notice of the delay.

2) Give the Member a written notice of the reason to extend the timeframe within two (2) calendar days, including information on the right to file an additional Grievance for the delay.

3) Resolve **the Appeal** as expeditiously as the Member's health condition requires and no later than the date the extension expires.

~~D~~ **E.** Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date it reverses the action, if the services are not furnished while the Appeal is pending and Contractor reverses a decision to deny, limit, or delay services.

~~E~~ **F.** Contractor must pay for disputed services if the Member received the disputed services while the Appeal was pending.

~~F~~ **G**. Contractor shall continue providing Covered Services while the Appeal is pending if all of the following conditions are met:

1) The Member filed their Appeal within the required timeframes,

2) The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

3) The Covered Services were ordered by an authorized Provider;

4) The period covered by the original authorization has not expired; and

5) The Member files for continuing Covered Services within 10 calendar days of when the NOA was sent, or before the intended effective date of the proposed action.

~~G~~ **H**. If Contractor, at the Member's request, continues or reinstates the provision of Covered Services while an Appeal or State Fair Hearing is pending, those services must continue until:

1) The Member withdraws their request for an Appeal or a State Fair Hearing;

2) The Member fails to request a State Fair Hearing and continuation of Covered Services within 10 calendar days of when the NOA was sent; or

3) The State Fair Hearing decision is adverse to the Member.

~~H~~ **I**. The Member must be given the opportunity before and during their Appeals process to examine their case file, including medical records and any other documents and records considered during the Appeals process. Contractor shall provide, sufficiently in advance of the resolution timeframe and free of charge, the Member's case file, including medical records and any other documents and records considered during the Appeal process.

6. Responsibilities in Expedited Appeals

Contractor shall implement and maintain procedures as described below to resolve expedited Appeals. Contractor shall follow the expedited Appeal process when it determines or the **requesting** Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

A. A Member, ~~or~~ a Provider or **an** authorized representative acting on behalf of a Member and with the Member's written consent, may file an expedited Appeal either orally or in writing**.** ~~n~~**N**o additional ~~Member~~ follow-up **from the Member** is required. Contractor must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's Appeal.

B. Contractor must inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, sufficiently in advance of the resolution timeframe.

C. Contractor must provide a Member notice, as quickly as the Member's health condition requires, within 72 hours from the day Contractor receives the request for an Appeal.

~~D.~~ Contractor may extend the timeframe to resolve an expedited Appeal by up to 14 days if the Member requests an extension or if Contractor shows that there is a need for additional information and how the delay is in the Member's interest. If the extension was not requested by the Member, Contractor shall make reasonable efforts to give the Member a prompt oral notice of the delay, and within two (2) calendar days**, provide** the Member **with** ~~a~~ written notice ~~of~~ **that includes** ~~both~~ the reason ~~for~~ **Contractor needs** the extension**. The notice shall include information on** ~~and~~ the right to file a Grievance if the Member disagrees that **Contractor's extension is appropriate** ~~with the decision~~. Contractor shall resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. **Contractor shall maintain documentation to demonstrate to the Department, why the extension is necessary.**

~~E~~ **D**. Contractor must make a reasonable effort to provide oral notice of expedited Appeal decision.

~~F~~ **E**. If Contractor denies a request for an expedited resolution of an Appeal, it must process the request for an Appeal in accordance

with the standard Appeal process timeframes for resolutions and extensions as required in Provision 5 of this Attachment.

7. State Fair Hearings and Independent Medical Reviews

A. State Fair Hearings

1) Members, or a Provider or authorized representative acting on behalf of a Member and with the Member's written consent, may request a State Fair Hearing:

a) After receiving a notice of **Appeal** resolution ~~stating~~ **confirming** that Contractor's action has been upheld, and the request is made within 120 calendar days from the date on the notice of **Appeal** resolution; or

b) If the~~y~~ **Member is deemed to** have exhausted the Appeals process due to Contractor**'s** ~~failing~~ **failure** to ~~adhere~~ **comply** ~~to~~ **with** Appeal notice and timing requirements **Contractor shall maintain documentation to demonstrate to the Department, why the extension is necessary,** as stated in this Contract **the Member may request a Fair Hearing. In cases of such deemed exhaustion, Contractor must not request a dismissal of the Fair Hearing based on a failure to exhaust Contractor's internal Appeal process**.

2) Upon request, Contractor shall assist the Member with preparing for the State Fair Hearing and must provide the Member, upon request, with all documents, guidelines and clinical criteria Contractor relied on for its initial denial and anything Contractor considered during its internal Appeal process.

3) Contractor must provide its Statement of Position for the Fair Hearing to the Member and to the Department of Social Services at least two (2) working days before the hearing.

4) Contractor must ensure that an employee familiar with the facts of the case and Contractor's bases for upholding its Adverse Benefit Determination is available to participate in the hearing. Contractor must ensure that it provides accurate contact information for

Contractor's representative to ensure appearance at the hearing via telephone or in person.

~~2~~ **5**) ~~During~~ **In cases where** the State Fair Hearing ~~process~~ **decision overturns Contractor's decision**, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date Contractor receives notice ~~reversing the determination if the services are not furnished while the Hearing is pending and Contractor reverses a decision to deny, limit, or delay services~~ **that the State Fair Hearing decision reversed Contractor's decision**.

~~3~~ **6**) Contractor must pay for disputed services if the Member received the disputed services while the Hearing was pending.

7) The parties to a State Fair Hearing must include Contractor as well as the Member and their representative or the representative of a deceased Member's estate.

8) Contractor shall notify Members that the State must reach its decision for a standard State Fair Hearing within 90 days of the date of the request. For an expedited State Fair Hearing, the State must reach its decision within 72 hours of receipt of the expedited State Fair Hearing request. Contractor shall also comply with all other requirements as required by 42 section CFR 438.410, W&I Code 10951.5 and as outlined in APL XX-XXX.

B. Expedited State Fair Hearings

1) Within two (2) working days of being notified by DHCS or the California Department of Social Services (CDSS) that a Member has filed a request for State Fair Hearing which meets the criteria for expedited resolution, Contractor shall deliver directly to the designated/appropriate CDSS administrative law judge all information and documents which either support, or which ~~the~~ Contractor considered in connection with, the action which is the subject of the expedited State Fair Hearing. This includes, but is not necessarily limited to, copies of the relevant treatment

authorization request and NOA, plus any pertinent Appeal resolution notice **and all documents Contractor relied on for its denial, including clinical criteria and guidelines**. If the NOA**s** or ~~Appeal resolution notices~~ **NARs** are not in English, fully translated copies shall be transmitted to CDSS along with copies of the original NOA**s** and ~~Appeal resolution notice~~ **NARs**.

2) One or more of Contractor's representatives with knowledge of the Member's condition and the reason(s) for the action, which is the subject of the expedited State Fair Hearing, shall be available by phone during the scheduled Hearing.

C. Independent Medical Review (IMR)

1) Members have the right to request ~~from DMHC~~ an IMR of an action resulting in a Member request for an Appeal, or the outcome of an Appeal.

2) An IMR must be requested by a Member. Contractor shall not require a Member to request an IMR before, or use one as a deterrent to, requesting a State Fair Hearing.

3) IMRs shall be conducted by DMHC independently from either the Member or Contractor, and at no cost to the Member.

4) IMRs shall not extend any of the time frames stated in this Contract for Appeals, and shall not disrupt the continuation of Covered Services per 42 CFR 438.420.

8. **Continuation of Services Until Appeal and State Fair Hearing Rights Are Exhausted**

A. Contractor shall automatically continue providing Covered Services while the Appeal and State Fair Hearing are pending if all of the following conditions are met:

1) The Member filed their Appeal within the required timeframes set forth in 42 CFR 438.420,

2) The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

3) The Covered Services were ordered by an authorized Provider;

4) The period covered by the original authorization has not expired; and

5) The Member files for continuing Covered Services within 10 calendar days of when the NOA was sent, or before the intended effective date of the proposed adverse benefit determination.

B. If Contractor, at the Member's request, continues or reinstates the provision of Covered Services while an Appeal or State Fair Hearing is pending, those services must continue until:

1) The Member withdraws their request for an Appeal or a State Fair Hearing;

2) The Member fails to request a State Fair Hearing and continuation of Covered Services within 10 calendar days of when the NOA was sent; or

3) The final State Fair Hearing decision is adverse to the Member.

C. Contractor must pay for disputed services, until there is a final decision on the State Hearing, if the Member received the disputed services while the Appeal or State Fair Hearing was pending.

~~8. Parties to an Appeal or a State Fair Hearing~~

~~The parties to an Appeal or a State Fair Hearing include Contractor as well as the Member and his or her representative or the representative of a deceased Member's estate.~~

9. Discrimination Grievances

Contractor shall process a Grievance for discrimination as required by federal and State nondiscrimination law stated in 45 CFR § 84.7; 45 CFR § 92.7; 34 CFR § 106.8; 28 CFR § 35.107; and W&I Code § 14029.91(e)(4).

A. Contractor shall designate a discrimination Grievance coordinator responsible for ensuring compliance with federal

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and State nondiscrimination requirements, and investigating discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.

B. Contractor shall adopt procedures to ensure the prompt and equitable resolution of discrimination Grievances by Contractor. Contractor shall not require a Member or Potential Enrollee to file a discrimination Grievance with Contractor before filing with the DHCS Office of Civil Rights or the U.S. Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a discrimination Grievance resolution letter, Contractor shall submit the following information regarding the discrimination Grievance in a secure format to the DHCS Office of Civil Rights:

1) The original discrimination Grievance;

2) The Provider's or other accused party's response to the discrimination Grievance;

3) Contact information for the personnel primarily responsible for investigating and responding to the discrimination Grievance on behalf of Contractor;

4) Contact information for the person filing the discrimination Grievance, and for the Provider or other accused party that is the subject of the discrimination Grievance;

5) All correspondence with the person filing the discrimination Grievance regarding the discrimination Grievance, including, but not limited to, the discrimination Grievance acknowledgment letter and resolution letter; and

6) The results of Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

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XV. Exhibit A, Attachment 17, REPORTING REQUIREMENTS, is amended to read:

Contract Section	Requirement	Frequency
Exhibit A - SCOPE OF WORK		
Attachment 1 ORGANIZATION AND ADMINISTRATION OF THE PLAN		
2. A. Key Personnel (Disclosure Form)	Key Personnel (Disclosure Form)	Annually
Attachment 2 FINANCIAL INFORMATION		
2. Financial Audit Reports B. 1) **or** B. 2)	Annual certified Financial Statements and DMHC required reporting forms **or** Financial Statement	Annually
2. Financial Audit Reports B. 2)	Quarterly Financial Reports	Quarterly
4. Monthly Financial Statements	Monthly Financial Statements (If applicable)	Monthly
Attachment 3 MANAGEMENT INFORMATION SYSTEM		
2. Encounter Data Submittal C.	Encounter Data Submittal	Monthly
6. Network Data Reporting	**Network Data Submittal in the 274 Provider File**	**Monthly**
Attachment 4 QUALITY IMPROVEMENT SYSTEM (QIS)		
4. Quality Improvement Committee C.	Quality Improvement Committee meeting minutes	Quarterly
8. Quality Improvement Annual Report	Quality Improvement Annual Report	Annually
9. External Quality Review Requirements A. External Accountability Set (EAS) Performance Measures 2) b)	EAS Performance Measurement Rates	Annually
9. External Quality Review Requirements B. Under/Over-Utilization Monitoring	Reported rates	Annually
9. External Quality Review Requirements C. Performance Improvement Projects (PIPs)	QIP Proposals or Status Reports	Annually
10. Site Review E. Data Submission	Site Review Data	Semi-Annually
Attachment 6 PROVIDER NETWORK		
11. Provider Network Report	Provider Network Changes Report	Quarterly
11. Annual Provider Network Report	Provider Network Capacity Report	Annually

Contract Section	Requirement	Frequency
12. Plan Subcontractors	Plan Subcontractors Report	Quarterly
Attachment 9 ACCESS AND AVAILABILITY		
13. Cultural and Linguistic Program C. ~~Group~~ **Population** Needs Assessment 4)	~~Group~~ **Population** Needs Assessment Summary Report	Every 5 years
Attachment 10 SCOPE OF SERVICES		
5. Services for Members under Twenty-One (21) Years of Age B. Children's Preventive Services ~~5~~**4**)	Confidential Screening/Billing Report ~~Form PM 160-PHP~~	Monthly
~~5. Services for Members under Twenty-One (21) Years of Age G. Behavioral Health Treatment Services~~	~~BHT Reporting Template~~	~~Quarterly~~
8. Services for All Members G. Pharmaceutical Services and Provision of Prescribed Drugs 5)	Report of Changes to the Formulary	Annually
8. Services for All Members G. Pharmaceutical Services and Provision of Prescribed Drugs 7)	Report of Changes to the Formulary	Annually
Attachment 12 LOCAL HEALTH DEPARTMENT COORDINATION		
4. MOU Monthly Reports	Local Health Department - MOU's County Mental Health - MOU's (If deemed necessary)	Monthly until MOU is signed
Attachment 13 MEMBER SERVICES		
~~3. Call Center Reports~~	~~Call Center Reports~~	~~Quarterly~~
4. Written Member Information B.	Member Services Guide	Annually
Attachment 14 MEMBER GRIEVANCE AND APPEAL SYSTEM		
3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report C.	Grievance and Appeal Report	Quarterly
3. Grievance and Appeal Log and Grievance and Appeal Report **D.**	**Grievance and Appeal Data**	**Monthly**
Attachment 15 MARKETING		
3. Marketing Plan	Marketing Plan	Annually

Contract Section	Requirement	Frequency
A.		
Attachment 16 ENROLLMENTS AND DISENROLLMENTS		
1. Enrollment Program (PL 11-009)	Provider Directory	Semi-Annually
Attachment 19 COMMUNITY BASED ADULT SERVICES (CBAS)		
1. Provider Network F.	**Subcontracted CBAS Providers and Accessibility Standards Report**	**Annually**
~~5~~**4**. Required Reports for the CBAS Program A.	Provision of ECM Report	Quarterly
~~5~~**4**. Required Reports for the CBAS Program B.	CBAS Enrollment Report	Quarterly
~~5. Required Reports for the CBAS Program C.~~	~~Addition to Call Center Report~~	~~Quarterly~~
~~5~~**4**. Required Reports for the CBAS Program ~~D~~ **C**.	Addition to Grievance and Appeal Report	Quarterly
Attachment 20 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS		
3. Provider Network Reports A.	Addition to the Provider Network Report	Quarterly
3. Provider Network Reports B.	Outpatient Mental Health Services Providers Report	Monthly
Attachment 21 MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS)		
10. Required Reports for Managed Long Term Services and Supports A.	Support and Retention of Community Placement	Quarterly
10. Required Reports for Managed Long Term Services and Supports B.	Continuity of Care Requests	Monthly
10. Required Reports for Managed Long Term Services and Supports C.	Addition to the Provider Network Report	Quarterly
~~10. Required Reports for Managed Long Term Services and Supports D.~~	~~Addition to Call Center Reports~~	~~Quarterly~~
10. Required Reports for Managed Long Term Services and Supports ~~E~~ **D**.	Addition to Grievances and Appeals Report	Monthly
10. Required Reports for Managed Long Term Services and Supports ~~F~~ **E**.	PCP Assignment	Monthly
~~**Exhibit B - BUDGET DETAIL AND PAYMENT PROVISIONS**~~		

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Contract Section	Requirement	Frequency
~~12. Payment of Aids Beneficiary Rates A. Compensation at the AIDS Beneficiary Rate (ABR) 1) c)~~	~~AIDS Beneficiaries Rate (ABR) Invoice~~	~~Monthly~~
Exhibit E - ADDITIONAL PROVISIONS		
Attachment 2 PROGRAM TERMS AND CONDITIONS		
34. Treatment of Recoveries C. Recovery of Overpayment	Recovery of Overpayment Report	Annually

XVI. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, is amended to read:

9. Access and Availability

A. Submit policies and procedures that include requirements for:

1) Appointment scheduling

2) Routine specialty referral

3) First prenatal visit

4) Waiting times

5) After-hours calls

6) Unusual specialty services

B. Submit policies and procedures for ensuring the timely provision of access standards for:

1) Appropriate clinical timeframes

2) Standards for timely appointments

3) Shortening or expanding timeframes

4) Arranging timely appointments with a Provider shortage.

C. Submit policies and procedures for the timely referral and coordination of Covered Service to which Contractor or Subcontractor has objections to perform or otherwise support.

D. Submit policies and procedures for standing referrals.

E. Submit policies and procedures regarding 24-hr/day access without prior authorization, follow-up and coordination of emergency care services.

F. Submit policies and procedures regarding access to Certified Nurse Midwives and Certified Nurse Practitioners.

G. Submit applicable section of Member Services Guide stating Member's right to access family planning services without prior authorization.

H. Submit policies and procedures for the provision of and access to:

1) Family planning services

2) Sexually transmitted disease treatment

3) HIV testing and counseling services

4) Pregnancy termination

5) Minor consent services

6) Immunizations

I. Submit policies and procedures regarding access for disabled members pursuant to the Americans with Disabilities Act of 1990.

J. Submit policies and procedures regarding Contractor and Subcontractor compliance with the Civil Rights Act of 1964.

K. Submit policies and procedures regarding compliance with the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act, Section 1557 of the Patient Protection and Affordable Care Act, SB 223/SB 1423, and Gov. Code Section 11135, as required in APL 20-015

~~K~~ **L**. Submit a written description of the Cultural and Linguistic Services Program.

~~L~~ **M**. Submit a timeline and work plan for the development and performance of a Group Needs Assessment.

~~M~~ **N**. Submit policies and procedures for providing cultural competency, sensitivity or diversity training for staff, Providers, and Subcontractors.

~~N~~ **O**. Submit policies and procedures for monitoring and evaluation of the Cultural and Linguistic Services Program.

~~O~~ **P**. Submit policies and procedures for the provision of 24-hour interpreter services at all Provider sites.

~~P~~ **Q**. Submit policies and procedures describing the membership of the Community Advisory Committee (CAC) and how Contractor will ensure the CAC will be involved in appropriate policy decisions.

~~Q~~ **R**. Submit policies and procedures for providing medically necessary services through Out-of-Network Providers, including allowing access for the completion of Covered Services by an Out-of-Network Provider or terminated Provider.

~~R~~ **S**. Submit policies and procedures to ensure access for up to 12 months for SPD beneficiaries who have an ongoing relationship with a Provider.

10. Scope of Services

A. Submit policies and procedures for ensuring the provision of the Initial Health Assessments (IHA) for adults and children, including the Individual Health Education Behavioral Health Assessment (IHEBA) of the IHA.

B. Submit policies and procedures for administering the Health Risk Stratification and Assessment to SPD beneficiaries, including other health information used for risk stratification.

C. Submit Contractor's risk stratification mechanism or algorithm designed for the purpose of identifying newly enrolled SPD beneficiaries as high or low risk.

D. Submit the plan's risk assessment tool to be used to comprehensively assess an SPD beneficiaries' current health risk and help develop individualized care management plans.

E. Submit policies and procedures, including standards, for the provision of the following services for Members under 21 years of age:

1) Children's preventive services

2) Immunizations

3) Blood Lead screens

4) Screening for Chlamydia

5) EPSDT services

6) Medically Necessary BHT services

F. Submit policies and procedures for the provision of adult preventive services, including immunizations.

G. Submit policies and procedures for the provision of services to pregnant women, including:

1) Prenatal care

2) Use of American College of Obstetricians and Gynecologists (ACOG) standards and guidelines

3) Comprehensive risk assessment tool for all pregnant women

4) Referral to Specialists

H. Submit a list of appropriate hospitals available within the Provider Network that provide necessary high-risk pregnancy services.

I. Provide a detailed description of health education system including policies and procedures regarding delivery of services, administration and oversight.

J. Provide a list and schedule of all health education classes and/or programs.

K. Submit policies and procedures for the distribution and use of the Health Information Form (HIF) data submitted through the Member Evaluation Tool (MET).

L. Submit policies and procedures for the provision of:

1) Hospice care

2) Vision care – Lenses

3) Mental health services

4) Tuberculosis services

M. Submit standards and guidelines for the provision of pharmaceutical services and prescribed drugs, including providing at least a 72-hour supply of a covered outpatient drug when prescribed in an emergency.

N. Submit a complete drug formulary.

O. Submit a process for review of drug formulary.

P. Submit policies and procedures for conducting a Drug Utilization Review (DUR).

11. Case Management Including Coordination of Care

A. Submit procedures for monitoring the coordination of care provided to Members. Include procedures used to monitor the provision of Basic Case Management.

B. Submit procedures for administering and monitoring the provision of Complex Case Management to Members. Include procedures to identify members who may benefit from complex case management services.

C. Submit policies and procedures for ensuring the provision of Person-Centered Planning for SPD beneficiaries as part of case management and coordination of care.

D. Submit policies and procedures for ensuring the provision of Discharge Planning.

E. Submit policies and procedures for coordinating care of Members who are receiving services from a Targeted Case Management Provider.

F. Submit policies and procedures for the referral of Members under the age of 21 years that require complex case management services.

G. Submit policies and procedures for administration of a disease management program, including procedures for identification and referral of Members eligible to participate in the disease management program.

H. Submit policies and procedures for referral and coordination of care for Members in need of Specialty Mental Health Services from the county mental health plan or other community resources.

I. Submit policies and procedures for resolving disputes between Contractor and the county mental health plan.

J. Submit policies and procedures for identification, referral and coordination of care for Members requiring alcohol or substance use treatment services from both within and, if necessary, outside Contractor's Service Area.

K. Submit a detailed description of Contractor's program for Children with Special Health Care Needs (CSHCN).

L. Submit policies and procedures for identifying and referring children to the local CCS program.

M. Submit policies and procedures for the identification, referral and coordination of care for Members with developmental disabilities in need of non-medical services from the local Regional Center and the DDS-administered Home and Community Based Waiver Program. Include the duties of the Regional Center Liaison.

N. Submit policies and procedures for the identification, referral and coordination of care for Members at risk of developmental delay and eligible to receive services from the local Early Start Program.

O. Submit policies and procedures for case management coordination of care of LEA services, including Primary Care Physician involvement in the development of the Member's Individual Education Plan or Individual Family Service Plan.

P. Submit policies and procedures for case management coordination of care of Members who receive services through local school districts or school sites.

Q. Submit a description of the cooperative arrangement Contractor has with the local school districts, including the Subcontracts or written protocols/guidelines, if applicable.

R. Submit policies and procedures describing the cooperative arrangement that Contractor has regarding care for children in Foster Care.

S. Submit policies and procedures for identification and referral of Members eligible to participate in the HIV/AIDS Home and Community Based Waiver Program.

T. Submit policies and procedures for the provision of dental screening and covered medical services related to dental services.

U. Submit policies and procedures for coordination of care and case management of Members with the LHD TB Control Officer.

V. Submit policies and procedures for the assessment and referral of Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.

W. Procedures to identify and refer eligible Members for WIC services.

X. Submit policies and procedures for the assessment and subsequent disenrollment of Members eligible for the following services:

1) Major organ transplants

2) Waiver Programs

Y. Submit policies and procedures for assessment of transitional needs of members into and out of Complex Case Management services:

1) At the request of PCP or Member

2) Achievement of targeted outcomes

3) Change of healthcare setting

4) Loss or change in benefits

5) Member non-compliance

12. Local Health Department Coordination

A. Submit executed Subcontracts or documentation substantiating Contractor's efforts to enter into Subcontracts with the LHD for the following public health services:

1) Family planning services

2) STD services

3) HIV testing and counseling

4) Immunizations

B. Submit executed Subcontracts, Memoranda of Understanding, or documentation substantiating Contractor's efforts to negotiate an agreement with the following programs or agencies:

1) California Children Services (CCS)

2) Maternal and Child Health

3) Child Health and Disability Prevention Program (CHDP)

4) Tuberculosis Direct Observed Therapy

5) Women, Infants, and Children Supplemental Nutrition Program (WIC)

6) Regional Centers for Services for Persons with Developmental Disabilities.

7) Local Governmental Agencies for Targeted Case Management services.

8) County department for alcohol and substance use disorder treatment services.

C. Executed MOU or documentation substantiating Contractor's efforts to negotiate a MOU with the county mental health plan.

13. Member Services

A. Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and Providers.

B. Submit policies and procedures for providing communication access to SPD beneficiaries in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, plain language or written translations and oral interpreters, including for those who are limited English-proficient (LEP), or non-English speaking.

C. Submit the following consistent with the requirements of Exhibit E, Attachment 2, Provision 21, Confidentiality of Information. Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information.

D. Submit policies and procedures for addressing advance directives.

E. Submit policies and procedures for the training of Member Services staff.

F. Submit policies and procedures regarding the development content and distribution of Member information. Address appropriate reading level and translation of materials.

G. Submit final draft of Member Identification Card and Member Services Guide.

H. Submit policies and procedures for notifying Members of changes in availability or location of Covered Services.

I. Submit policies and procedures for Member selection of a Primary Care Physician or Non-Physician Medical Practitioner. Include the mechanism used for allowing SPD beneficiaries to request a Specialist to serve as their PCP.

J. Submit policies and procedures for Member assignment to a Primary Care Physician. Include the use of ~~FFS~~ utilization data and other data in linking a SPD beneficiary to a PCP.

K. Submit policies and procedures for notifying Primary Care Provider that a Member has selected or been assigned to the Provider within 7-days.

L. Submit policies and procedures demonstrating how, upon entry into Contractor's Network, the relationship between Traditional and Safety-Net Providers and their patients is not disrupted, to the maximum extent possible.

M. Submit policies and procedures for notifying Members for denial, deferral, or modification of requests for Prior Authorization.

14. Member Grievance and Appeal System

A. Submit policies and procedures relating to Contractor's Member Grievance and Appeal System.

B. Submit policies and procedures for Contractor's oversight of their Grievance and Appeal System for the receipts, processing and distribution including the expedited review of Appeals. Include a flow chart to demonstrate the process.

C. Submit format for Quarterly Grievance and Appeal Log and Report.

D. Submit policies and procedures relating to Contractor's Appeals process. Include Contractor's responsibilities in expedited Appeals and State Fair Hearings.

15. Marketing

A. Submit policies and procedures for training and certification of Marketing Representatives.

B. Submit a description of training program, including the marketing representative's training/certification manual.

C. Submit Contractor's marketing plan.

D. Submit copy of boilerplate request form used to obtain DHCS approval of participation in a marketing event.

16. Enrollments and Disenrollments

A. Submit policies and procedures for how Contractor will update and maintain accurate information on its contracting Providers.

B. Submit policies and procedures for how Contractor will access and utilize enrollment data from DHCS.

C. Submit policies and procedures relating to Member disenrollment.

17. Health Insurance Portability and Accountability Act (HIPAA)

Submit the following consistent with the requirements of Exhibit G.

A. Submit policies and procedures for compliance with the Health Insurance Portability and Accountability Act of 1996.

18. Community Based Adult Services (CBAS)

Submit the following consistent with the requirements of Exhibit A, Attachment 19.

A. Submit policies and procedures for referring a Member to a CBAS Provider.

B. Submit policies and procedures on arranging for the provision of CBAS unbundled services.

C. ~~Submit policies and procedures for providing Enhanced Case Management services.~~ **Submit all policies and procedures required by the Medi-Cal 2020 Waiver Special Terms and Conditions, Section VII.A.51.b.**

D. Submit policies and procedures for the initial assessment and reassessment of Members for eligibility to receive CBAS.

E. Submit policies and procedures for an expedited assessment process.

F. Submit final draft of the written notice to be sent to Members after a CBAS assessment determination that results in a change to the Member's CBAS benefit.

19. Mental Health and Substance Use Disorder Benefits

Submit the following consistent with the requirements of Exhibit A, Attachment 20.

A. Submit policies and procedures for adding licensed mental health Providers to the Network, including which services shall be offered by licensed mental health Providers.

B. Submit policies and procedures for ensuring timely access to Outpatient Mental Health Services.

C. Submit any Subcontract boilerplate developed for a county mental health plan.

D. Submit policies and procedures for subcontracting with county mental health plans in order to comply with access standards.

E. Submit policies and procedures for verifying the credentials of licensed mental health Providers of Outpatient Mental Health Services.

F. Submit policies and procedures for contracting with out-of-Network and Telehealth mental health services Providers.

G. Submit policies and procedures for exchanging Member information with the county mental health plan.

H. Submit policies and procedures for handling of psychiatric emergencies during non-business hours.

I. Submit policies and procedures that define and describe what mental health services are to be provided by a licensed mental health care Provider.

J. Submit policies and procedures for when a Member becomes eligible for Specialty Mental Health Services during the course of receiving medically necessary Outpatient Mental Health Services.

K. Submit policies and procedures for the provision of Alcohol Misuse Screening and Counseling (AMSC) services, including:

    1) Provision of AMSC by a Member's PCP to identify, reduce, and prevent problematic substance use;

2) Referral without requiring Prior Authorization, to AMSC services for Members whose PCPs do not offer AMSC; and

3) Referral ~~without requiring Prior Authorization,~~ of Members to substance use disorder treatment **without requiring Prior Authorization,** when there is a need beyond AMSC.

20. Managed Long-Term Services and Supports

Submit the following consistent with the requirements of Exhibit A, Attachment 21.

A. Submit policies and procedures for the provision of services at non-contracted Long Term Care (LTC) facilities.

B. Submit an addition to the policies and procedures related to Provider training required in Provision 7 of this Attachment that includes key elements of operating a successful program for administering MLTSS.

C. Submit policies and procedures for the provision of LTC, and the Multipurpose Senior Services Program (MSSP), as Covered Services.

XVII. Exhibit A, Attachment 19, COMMUNITY BASED ADULT SERVICES, is amended to read:

1. Provider Network

In addition to Exhibit A, Attachment 6, Provider Network, Contractor also agrees to the following:

A. ~~Contractor shall ensure that every ADHC Provider within their service area that has been approved by the California Department of Aging as a CBAS Provider as of July 1, 2012, is included in their Network, to the extent that the CBAS Provider remains licensed, certified, operating, and is willing to enter into a subcontract with Contractor on mutually agreeable terms and meets the Contractor's credentialing and quality standards.~~ **Subcontracting with a sufficient number of available CBAS Providers in Contractor's Services Area to meet the expected utilization without a waitlist and ensure timely access, within on hour's transportation time, for Members who meet the CBAS eligibility criteria in the 2020 Waiver Special Terms and**

Conditions, Section VIII.A.48. Subcontracted CBAS Providers must be appropriate for and proficient in addressing CBAS-eligible Members' specialized health care needs, and their acuity, communication, cultural and language needs and preferences.

B. ~~If Contractor determines that additional CBAS Providers are necessary to meet the needs of its Members, Contractor may extend a contract to any CBAS Provider certified by the California Department of Aging after July 1, 2012. Contractor shall consider a Member's relationship with previous CBAS Providers when ensuring access to CBAS. Contractor shall not be required to include CBAS Providers that were certified by the California Department of Aging after July 1, 2012 in their Provider Network.~~ **Contractor may, but is not obligated to, subcontract with CBAS Providers licensed as ADHCs and certified by the CDA to provide CBAS on or after April 1, 2012.**

C. If Contractor determines that Member needs for CBAS exceeds Contractor's CBAS Provider capacity, Contractor shall arrange for access to unbundled services in accordance with the ~~California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91.m~~ **2020 Waiver Special Terms and Conditions, Section VIII.A.48.b**.

~~D. Contractor shall include CBAS Provider information within the quarterly Provider Network Report submission in Exhibit A, Attachment 6, Provision 11~~.

~~E~~ **D**. Contractor may exclude any CBAS Provider from its Network, to the extent that the Contractor and CBAS Provider cannot agree to terms, the CBAS Provider does not meet Contractor's credentialing or quality standards, is terminated pursuant to the terms of the CBAS Provider's contract with Contractor, or otherwise ceases its operations as a CBAS Provider.

~~F~~ **E**. Contractor shall notify DHCS when unable to contract with a certified CBAS Provider or upon termination of a CBAS Provider contract:

1) If Contractor and a CBAS Provider cannot agree on mutually agreeable terms, the Contractor must notify DHCS within five (5) working days of the Contractor's decision to exclude the CBAS Provider from its Provider Network. DHCS will attempt to resolve the contracting issue when appropriate.

2) Contractor shall provide DHCS with notice of its termination of a CBAS Provider contract at least 60 days prior to the contract termination effective date.

F) Contractor shall provide DHCS with a list of its subcontracted CBAS Providers and its CBAS accessibility standards on an annual basis.

2. Covered Services

In addition to Exhibit A, Attachment 10, Provision 1, Covered Services and in accordance with the ~~California Bridge to Reform Waiver 11-W-00193/9~~ **2020 Waiver**, Special Terms and Conditions, ~~Paragraph 91.f. and g~~. **Sections VIII.A.49 and 51**, Contractor ~~agrees to provide~~ **shall cover** CBAS ~~from October 1, 2012 through August 31, 2014, and shall~~ **and ensure provision of the following services**:

A. Arrange for the provision of CBAS to Members determined eligible to receive CBAS in accordance with ~~Provision 4, Assessment and Reassessment of Community Based Adult Services~~ **the 2020 Waiver Special Terms and Conditions, Section VIII.A.48.d, and Provision 3 below**.

B. Consider a Member's relationship with a previous Provider of services similar to CBAS when referring a Member to a CBAS Provider.

C. ~~Seek to offer~~ **Cover** CBAS as a bundled service through a ~~certified~~ CBAS Provider~~.~~ **or arrange for the provision of unbundled CBAS based on the assessed needs of the Member if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area. Unbundled services authorized by Contractor are limited to:**

1) Professional Nursing Services;

2) Nutrition;

3) Physical Therapy;

4) Occupational Therapy;

5) Speech and Language Pathology Services;

6) NEMT, only between a Member's home and the CBAS unbundled service Provider; and

7) Behavioral Health Treatment (BHT) services for Members under 21 years of age.

~~D. Arrange for the provision of unbundled services based on the assessed needs of the Member eligible for CBAS if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area. In accordance with the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91.m. unbundled services are limited to:~~

~~1) Services authorized by Contractor~~

~~a) Professional Nursing Services~~

~~b) Nutrition~~

~~c) Physical Therapy~~

~~d) Occupational Therapy~~

~~e) Speech and Language Pathology Services~~

~~f) Non-Emergency Medical Transportation only between the Member's home and the CBAS unbundled service Provider~~

~~2) Services coordinated by Contractor. In addition to the requirements for unbundled CBAS contained in this provision, and in accordance with Exhibit A, Attachment 11, Provision 5, Out-of-Network Case Management and Coordination of Care, Contractor shall coordinate care for unbundled CBAS, based on the assessed needs of the member eligible for CBAS, that are not covered services, including:~~

~~a) Personal Care Services~~

~~b) Social Services~~

~~c) Physical and Occupational Maintenance Therapy~~

~~d) Meals~~

~~e) Mental Health Services~~

~~E. If a Member has been determined CBAS eligible by DHCS and is receiving care from a CBAS Provider pending assessment by the Contractor, Contractor shall continue the provision of CBAS until an assessment has been completed in accordance with Provision 4, Assessment and Reassessment of Community Based Adult Services.~~

~~F. Contractor shall not impede or delay Member access to Medicare Providers or services through its provision of CBAS or ECM.~~

3. ~~Enhanced Case Management~~ <u>Coordination of Care</u>

~~Contractor shall provide ECM benefits in accordance with the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 92.b. and in addition to Exhibit A, Attachment 11, Provision 1, Comprehensive Case Management Including Coordination of Care Services.~~

~~A. Contractor shall ensure the provision of Enhanced Case Management (ECM) services from April 1, 2012, through August 31, 2014 to Members who received Adult Day Health Care (ADHC) services from Medi-Cal at any time between July 1, 2011 and February 29, 2012 and who are determined to be ineligible for CBAS.~~

~~B. A Member determined to be eligible for ECM may at a later date be determined eligible for CBAS. If the Member receives CBAS, the Member will no longer receive ECM. If at a later time the Member no longer receives CBAS, the Member will then be eligible to receive ECM.~~

~~C. A Member eligible for ECM who receives CBAS at some time between April 1, 2012 and August 31, 2014, is eligible to receive ECM for any time period during which they do not receive the CBAS benefit. A Member shall not receive ECM and CBAS concurrently.~~

~~D. For Members who had received ADHC services between July 1, 2011 and February 29, 2012 but are ineligible to receive CBAS, Contractor shall continue to approve the provision of CBAS until ECM service referrals are made, a care plan has been developed, and Contractor has referred the Member to services as advised in the care plan.~~

~~E. Contractor may contract with a CBAS Provider or other appropriate entity for the provision of ECM services to eligible Members.~~

~~F. Contractor shall attempt to contact Members who had received ADHC services between July 1, 2011 and February 29, 2012 but are ineligible to receive CBAS a minimum of three (3) separate times to initiate ECM. If the Member refuses to engage in ECM or Contractor is unable to make contact with the Member after three (3) separate attempts, Contractor's obligation will have been met. Contractor shall provide ECM services in accordance with the requirements in this provision if the Member requests it after outreach effort obligations have been met.~~

In addition to Exhibit A, Attachment 11, Case Management and Coordination of Care, Contractor also agrees to the following:

A. Contractor shall provide continuity of care to Members through continued access to a CBAS Provider with whom there is an existing relationship for up to 12 months after Member enrollment. This requirement shall include Out-of-Network Providers if there are no quality of care issues and the Provider will accept either Contractor or Medi-Cal FFS rates, whichever is higher, per the continuity of care requirements set forth in Exhibit A, Attachment 9, Access and Availability, Provision 16, Out-of-Network Providers.

B. Contractor shall ensure that CBAS IPCs are consistent with the Members' overall care plans and goals.

C. Contractor shall ensure that the initial assessment and reassessment procedures for Members requesting CBAS are done in accordance with the 2020 Waiver Special Terms and Conditions, Section VIII.A.48.e., Section VIII.A.51.b., and as follows:

1) Conduct the CBAS eligibility determination using a DHCS-approved assessment tool. CBAS eligibility determinations shall include a face-to-face review with

the Member by a Registered Nurse with level of care determination experience.

2) Develop and implement an expedited assessment process to determine CBAS eligibility within 72 hours of receipt of a CBAS authorization request for a Member in a hospital or SNF whose discharge plan includes CBAS, or who is at high risk of admission to a SNF, or who faces an imminent and serious threat to their health.

3) Reassessment and redetermination of the Member's eligibility for CBAS is done at least every six (6) months after the initial assessment or up to every 12 months for Members when determined by Contractor to be clinically appropriate. When a Member requests that services remain at the same level or an increase in services due to a change in their level of need, Contractor may conduct the reassessment using only the Member's IPC, including any supporting documentation supplied by the CBAS Provider.

4) Contractor shall not deny, defer, or reduce a requested level of CBAS for a Member without a face-to-face review performed by a Registered Nurse with level of care determination experience and utilizing the assessment tool approved by DHCS.

5) Contractor shall notify Members in writing of the CBAS assessment determination in accordance with the timeframes identified in the 2020 Waiver Special Terms and Conditions, Section VIII.A.51.b. Contractor's written notice shall be approved by DHCS and include procedures for Grievances and Appeals in accordance with current requirements identified in Exhibit A, Attachment 14, Member Grievance and Appeal System.

6) Require that CBAS Providers update a Member's CBAS Discharge Plan of Care and provide a copy to the Member and to Contractor whenever a Member's CBAS services are terminated.

D. Contractor shall coordinate Member care with CBAS Providers to ensure the following:

1) Exchange of the following information, conducted in a

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timely manner to facilitate care coordination: Member discharge plan information; reports of incidents that threaten the welfare, health and safety of the Member; and significant changes in the Member's condition.

2) Clear communication pathways between the appropriate CBAS Provider staff and Contractor personnel responsible for CBAS eligibility determination, authorization, and care planning, including identification of the lead care coordinator for Members who have a care team, and utilization management.

3) Written notification of Contractor's policy and procedure changes, and a process to provide education and training for CBAS Providers regarding any substantive changes that may be implemented, prior to the policy and procedure changes taking effect.

E. In addition to the requirements for unbundled CBAS contained in Provision 2, and in accordance with Exhibit A, Attachment 11, Provision 5, Out-of-Network Case Management and Coordination of Care, Contractor shall coordinate care for unbundled CBAS that are not Covered Services, based on the assessed needs of the Member eligible for CBAS, including:

1) Personal Care Services

2) Social Services

3) Physical and Occupational Maintenance Therapy

4) Meals

5) Specialty Mental Health Services

6) Behavioral Health Treatment (BHT) for Members over the age of 21 years

~~**4. Assessment and Reassessment for CBAS**~~

~~Contractor shall ensure that the initial assessment and reassessment procedures for Members requesting CBAS, or who have previously been deemed eligible to receive CBAS, meet the following minimum requirements:~~

A. Contractor shall ensure appropriate staff responsible for conducting, managing, and/or training for an initial assessment or reassessment of Members for CBAS shall receive training from DHCS on using the approved assessment tool.

B. Contractor shall conduct the CBAS eligibility determination of a Member requesting CBAS using the assessment tool approved by DHCS. CBAS eligibility determinations shall include a face-to-face review of the Member. Contractor shall include a Registered Nurse with level of care experience and a social worker on the assessment team, either as an employee or as a sub-contractor.

C. Contractor shall develop and implement an expedited assessment process to determine CBAS eligibility when informed of Members in a hospital or skilled nursing facility whose discharge plan includes CBAS, or who are at high risk of admission to a skilled nursing facility.

D. Contractor shall reassess and redetermine the Member's eligibility for CBAS at least every six (6) months after initial assessment, or whenever a change in circumstances occurs that may require a change in the Member's CBAS benefit.

E. If Member is already receiving CBAS and requests that services remain at the same level or be increased due to a change in level of need, Contractor may conduct the reassessment using only the Member's IPC, including any supporting documentation supplied by the CBAS Provider.

F. Contractor shall not deny, defer, or reduce a requested level of CBAS for a Member without a face-to-face review performed by a Registered Nurse with level of care experience and utilizing the assessment tool approved by DHCS.

G. Contractor shall notify Members in writing of the CBAS assessment determination in accordance with the timeframes identified in Exhibit A, Attachment 13, Provision 8, Denials, Deferrals, or Modifications of Prior Authorization Requests. Contractor's written notice shall be approved by DHCS and include procedures for Grievances and Appeals in accordance with current requirements identified in Exhibit A, Attachment 14, Member Grievance and Appeal System.

~~H. Contractor shall require that CBAS Providers complete a CBAS Discharge Plan of Care for any Members who have been determined to no longer need CBAS.~~

~~5~~ 4. Required Reports for the CBAS Program

Contractor shall submit to DHCS the following reports 30 calendar days following the end of the reporting quarter and in a format specified by DHCS.

~~A. Contractor shall report to DHCS the number of Members who received ADHC services from July 1, 2011 to February 29, 2012 and have been determined ineligible to receive CBAS and have received ECM services, within the specified reporting time period .~~

~~B~~ **A**. Contractor shall report to DHCS how many Members have been assessed for CBAS, the total number of Members currently being provided with CBAS, both as a bundled or unbundled service.

B. In addition to the requirements in Exhibit A, Attachment 6, Provider Network, Provision 11, Provider Network Report, Contractor shall include CBAS Providers added to or deleted from Contractor's Provider Network, within the quarterly Provider Network Report submission.

~~C. In addition to the requirements set forth in Exhibit A, Attachment 13, Provision 3, Call Center Reports, Contractor shall also include a review of any complaints surrounding the provision of CBAS benefits.~~

~~D~~ **C**. In addition to the requirements set forth in Exhibit A, Attachment 14, Provision 3, Grievance Log and Grievance Quarterly Reports, Contractor shall also include reports on the following areas:

1) Appeals related to requesting CBAS and inability to receive those services or receiving more limited services than requested

2) Appeals related to requesting a particular CBAS Provider and inability to access that Provider

3) Excessive travel times to access CBAS

4) Grievances regarding CBAS Providers

5) Grievances regarding Contractor assessment and/or reassessment.

~~**6. Payment Rates to CBAS Providers**~~

~~A. All CBAS Providers, whether contracted or not, will be reimbursed for providing the CBAS benefit between July 1, 2012 and August 31, 2014 at the rate described below, minus ten percent, except in exempted Medical Service Study Areas, which will receive the rates below:~~

~~1) Comprehensive multidisciplinary evaluation - $80.08 per evaluation.~~

~~2) Community-Based Adult Services, adult - $76.27 per day.~~

~~3) Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter - $64.83 per encounter.~~

~~B. Contractor shall not be required to pay more than the Medi-Cal fee schedule as detailed in the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91.m. for unbundled CBAS.~~

XVIII. Exhibit A, Attachment 21, MANAGED LONG-TERM SERVICES AND SUPPORTS, is amended to read:

10. Required Reports for Managed Long Term Services and Supports

Contractor shall submit to DHCS the following reports:

A. Contractor shall provide to DHCS a quarterly report on MLTSS. Contractor shall submit these reports in templates provided by DHCS. Templates are subject to revisions; DHCS will communicate updates via email to Contractor.

B. Contractor shall report to DHCS, on a monthly basis and in a format specified by DHCS, the number of continuity of care requests, and the outcomes of those requests, for Full Benefit Dual Eligible, Partial Dual Eligible, and Medi-Cal Only Members.

C. In addition to the requirements in Exhibit A, Attachment 6, Provider Network, Provision 11. Provider Network Report, Contractor shall include LTC Providers added to or deleted from Contractor's Provider Network, within the quarterly Provider Network Report submission.

~~D. In addition to the requirements set forth in Exhibit A, Attachment 13, Member Services, Provision 3. Call Center Reports, Contractor shall report to DHCS on calls related to Member satisfaction with LTC, CBAS, and MSSP within the quarterly Call Center Report submission. The quarterly Call Center Report shall also include calls related to MSSP Grievances and Appeals, and whether Contractor has referred any Grievances or Appeals to MSSP site.~~

~~E~~ **D**. In addition to the requirements set forth in Exhibit A, Attachment 14, Member Grievance and Appeal System, Provision 3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report, Contractor shall also report to DHCS on a monthly basis the number and percentage of Grievances or Appeals that have been submitted in relation to a Member receiving LTC services. Contractor shall not be responsible for reporting Grievances, Appeals, or resolutions related to a Member receiving MSSP if they were reported to the MSSP site.

~~F~~ **E**. Contractor shall report to DHCS the number of Partial Dual Eligible or Medi-Cal Only Members who were assigned to a Primary Care Provider on a monthly basis and in a format specified by DHCS.

11. Risk Corridor

A. A Risk Corridor shall be established for a period of 24 months, effective April 1, 2014 and ending on March 31, 2016 for Full Benefit Dual Eligible Members as defined in Exhibit E, Definitions, of this Contract.

B. A ~~r~~ **R**isk ~~c~~ **C**orridor shall also be established for a period of 24 months, effective July 1, 2014 and ending on June 30, 2016 for Partial Dual Eligible Members and Medi-Cal Only Members as defined in Exhibit E, Definitions, of this Contract.

XIX. Exhibit B, BUDGET DETAIL AND PAYMENT PROVISIONS, is amended to read:

Budget Detail and Payment Provisions

1. Budget Contingency Clause
2. Amounts Payable
3. Contractor Risk in Providing Services
4. Capitation Rates
5. Capitation Rates Constitute Payment in Full
6. Determination of Rates
7. Redetermination of Rates-Obligation Changes
8. Reinsurance
9. Catastrophic Coverage Limitation
10. Financial Performance Guarantee
11. Recovery of ~~Capitation Payments~~ **Amounts Paid to Contractor**
~~12. Payment of Aids Beneficiary Rate~~
13 ~~3~~ **2**. Medical Loss Ratio (MLR)
14 ~~3~~ **3**. Adult Expansion ~~Medical Loss Ratio and~~ Risk Corridor
15 ~~4~~ **4**. Supplemental Payments
16 ~~5~~ **5**. Special Contract Provisions Related to **Directed** Payment **Initiatives and Pass-Through Payment Programs**
16. Special Contract Provisions Related to Incentive Arrangements
17. Medicare Coordination
18. Covid-19 Risk Corridor

4. Capitation Rates

A. DHCS shall remit to Contractor a Capitation Payment each month for each ~~Medi-Cal~~ Member that appears on the approved list of Members supplied to Contractor by DHCS. ~~The capitation rate shall be the amount specified below.~~ The payment period for health care services shall commence on the first day of operations, as determined by DHCS. Capitation Payments shall be made in accordance with the following schedule of ~~Capitation Payment~~ **capitation** rates ~~at the end of the month~~. For aid codes**,** see DEFINITIONS, Eligible Beneficiary:

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For the period 07/01/1~~7~~9 – ~~06/30/18~~ 12/31/2020	**County Rates**
Groups	
Adult & Family/Optional Targeted Low-Income Child (Under 19)	
Adult & Family/Optional Targeted Low-Income Child (19 & Older)	
Adult & Family/Optional Targeted Low-Income Child (Dual)	
~~Family & Dual Eligible~~	
SPD	
SPD/Dual	
SPD/Dual ~~Eligible~~ **(Non-CCI)**	
Long Term Care/Full Dual ~~Eligible~~	
Long Term Care/Non-Full Dual ~~Eligible~~	
Long Term Care/Full Dual (Non-CCI)	
Breast and Cervical Cancer Treatment Program (BCCTP)	
Maternity	
Adult Expansion	
Maternity Expansion	
Hepatitis C/340B	
Hepatitis C/Non-340B	
HCBS High	
~~HCBS Low~~	
BHT/Ages 0-6	
BHT/Ages 7-20	

B. If DHCS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral revenue effect for the Contractor, then the split aid code will automatically be included in the same aid code rate group as the original aid code covered under this Contract. Contractor agrees to continue providing Covered Services to the Members at the ~~monthly capitation~~ **Capitation Payment** rate specified for the original aid code. DHCS shall confirm all aid code splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practicable after such aid code splits occur.

C. ~~Pursuant to~~ **In accordance with** 42 CFR **section** 438.~~6(b)(1)~~**7**, the actuarial basis for the computation of the Capitation Payment rates shall be set forth in DHCS' ~~most recent version of the annually-published Rate Manual for the rate period that is identified above. Said Rate Manual~~ **rate certification for the applicable rate**

period. The rate certification is incorporated by reference in Exhibit E, **Attachment 2,**Provision 1.

D. For Dual payment rates that are not identified in the schedule of Capitation Payment rates above, DHCS shall pay a capitated rate as stated in an M Letter sent to Contractor by DHCS. The M Letter shall serve as notification from DHCS to Contractor of the capitated rates for Dual payment rates not stated in this Contract, and the time period for which these rates will be applied. The M Letter shall not be considered exempt from any requirement of this Contract. The rates supplied in the M Letter will be adjusted within 30 days from the date of release.

E. By January 1, 2015, and annually thereafter, DHCS shall provide an amendment to this Contract to add Dual payment rates that have been sent to Contractor through the M Letter.

5. Capitation Rates Constitute Payment In Full

Except as otherwise specified in this Contract, the c~~C~~apitation rates for each ~~rate period~~ **Rating Period**, as calculated by DHCS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by ~~the~~ Contractor in providing or arranging for such services. **Except as otherwise specified in the Contract,** DHCS is not responsible for making payments ~~for recoupment of~~ **associated with Contractor's** losses.

6. Determination ~~O~~of Rates

A. DHCS shall determine the capitation rates for the ~~initial period October 1, 2004 or the~~ Contract effective date of Operations, ~~through September 30, 2005 subsequent to September 30, 2005 and~~ through the duration of the Contract. DHCS shall **redetermine** ~~make an annual redetermination of~~ rates in accordance with ~~Title 22 CCR Section 53869~~ **W&I Code section 14301.1** for each **Rating Period** ~~rate year defined as the 12-month period from October 1 through September 30. DHCS reserves the right to establish rates on an actuarial basis for each rate year~~. All payments and rate adjustments are subject to appropriations of funds by the Legislature and the Department of Finance approval.

Further, all payments are subject to the availability of Federal congressional appropriation of funds.

B. Once DHCS establishes rates on an actuarially sound basis, it shall determine whether the rates shall be increased, decreased, or remain the same. If it is determined by DHCS that Contractor's capitation rates shall be increased or decreased, the increase or decrease shall be effectuated through an amendment/change order to this Contract in accordance with the provisions of Exhibit E, Attachment 2, Provision 4, Change Requirements, subject to the following provisions:

1) The amendment/change order shall be effective as of ~~July 1~~ **the first day of the Rating Period** of each ~~year~~ **Rating Period** covered by this Contract.

2) In the event there is any delay in a determination to increase or decrease capitation rates, so that an amendment/change order may not be processed in time to permit payment of new rates commencing ~~July 1~~ **the first day of the Rating Period**, the payment to Contractor shall continue at the rates stated in an R Letter sent to the Contractor by DHCS. The R Letter shall serve as notification from DHCS to Contractor of the capitated rates, and the time period for which these rates will be applied. The R Letter shall not be considered exempt from any requirement of this Contract. Those continued payments shall constitute interim payment only. Upon CMS final approval of the amendment/change order and rate certification, providing for the rate change, DHCS shall make retroactive adjustments for those months for which interim payment was made.

3) By accepting payment of new ~~annual~~ **capitation** rates prior to full approval by ~~all control agencies~~ **CMS** of the amendment/change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any **and all** amounts received in excess of the final approved rate. ~~If~~ **In** the **event that the** final approved rate differs from the rates established by DHCS or agreed upon by Contractor and DHCS:

a) Any underpayment by the State shall be paid to Contractor within 30 calendar days after final approval

of the new rates. **DHCS will provide Contractor a timeframe for payment of any underpayments.**

b) **Unless otherwise required by CMS, ~~A~~any** ~~o~~**O**verpayment to Contractor shall be ~~recaptured~~ **offset** by the State's withholding ~~the amount due~~ from Contractor's ~~next capitation check~~ **future Revenues of any amount due**. ~~If the amount to be withheld from that capitation check exceeds 25 percent of the capitation payment~~ ~~for that~~ **DHCS may, at its discretion, withhold up to 100 percent of Contractor's Revenues for each** month~~, amounts up to 25 percent shall be withheld from successive capitation payments~~ until **any** ~~the~~ ~~o~~**O**verpayment is fully recovered by the State.

4) If mutual agreement between DHCS and Contractor cannot be attained on capitation rates for **Rating Periods** ~~rate years~~ subsequent to September 30, 2005 resulting from a rate change pursuant to this Provision 6 or Provision 7 below, Contractor shall retain the right to terminate the Contract~~, but no earlier than September 30, 2006~~. Notification of intent to terminate a Contract shall be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Attachment 2, Provision 14, regarding Termination – Contractor. DHCS shall pay the capitation rates last offered for that ~~r~~**R**ate**ing** ~~p~~**P**eriod until the Contract is terminated.

5) DHCS shall make every effort to notify and consult with Contractor regarding proposed redetermination of rates pursuant to this section or Provision 7, below at the earliest possible time prior to implementation of the new rate.

7. Redetermination ~~O~~of Rates - Obligation Changes

The capitation rates may be adjusted ~~during the~~ ~~rate year~~ to provide for a change**s** in obligations ~~that results in an increase or decrease of more than one percent of cost (as defined in Title 22 CCR Section 53869) to the Contractor~~ **in accordance with W & I Code section 14301.1 and 42 CFR section 438.4, or as deemed necessary by DHCS**. Any adjustments shall be effectuated through a change order to the Contract subject to the following provisions:

A. The change order shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS.

B. In the event DHCS is unable to process the change order in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor shall continue at the rates then in effect. Continued payment shall constitute interim payment only. Upon final approval of the change order providing for the change in obligations, DHCS shall make adjustments for those months for which interim payment was made.

C. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Attachment 2, Provision 14, regarding Termination – Contractor, if a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this provision.

8. Reinsurance

Contractor may obtain reinsurance (stop loss coverage) to ensure maintenance of adequate capital by Contractor for the cost of providing Covered Services under this Contract. Pursuant to Title 22 CCR Section 53252 (a)(2)(A)&(B), reinsurance shall not limit Contractor's liability below $5,000 per Member for any 12-month period as specified by DHCS, and Contractor may obtain reinsurance for the total cost of services provided to Members by non-contractor emergency service Providers and for 90 percent of all costs exceeding 115 percent of its income during any Contractor fiscal year.

9. Catastrophic Coverage Limitation

DHCS may limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to Members, which results from or is greatly aggravated by a catastrophic occurrence or disaster. Contractor will return a prorated amount of the Capitation Payment following the DHCS Director's invocation of the catastrophic coverage limitation. The amount returned will be determined by dividing the total Capitation Payment by the number of days in the month. The amount will be returned to DHCS for

each day in the month after the Director has invoked the catastrophic coverage limitation clause.

10. Financial Performance Guarantee

Contractor shall provide satisfactory evidence of, and maintain Financial Performance Guarantee in, an amount equal to at least one Capitation Payment, in a manner specified by DHCS. At the Contractor's request, and with DHCS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Contractor may elect to satisfy the Financial Performance Guarantee requirement by receiving payment on a post payment basis. The Financial Performance Guarantee shall remain in effect for a period not exceeding 90 calendar days following termination or expiration of this Contract unless DHCS has a financial claim against Contractor. Further rights and obligations of the Contractor and DHCS, in regards to the Financial Performance Guarantee, shall be as specified in Title 22 CCR Section 53865.

11. Recovery ~~Of Capitation Payments~~ of Amounts Paid to Contractor

DHCS shall have the right to recover from Contractor amounts paid to Contractor in the following circumstances as specified:

A. If DHCS determines that a Member has either been improperly enrolled due to ineligibility of the Member to enroll in Contractor's ~~plan,~~ **Medi-Cal Managed Care Health Plan, a Member's** residence **is** outside of Contractor's Service Area, ~~or pursuant to Title 22, Section 53891(a)(2),~~ or **a Member** should have been disenrolled with an effective date in a prior month, DHCS may recover ~~the Capitation Payments made~~ **amounts paid** to Contractor for the Member for the months in question. **In such event,** ~~T~~**t**o the extent permitted by law, Contractor may seek to recover any payments made to Providers for Covered Services rendered for the month(s) in question. Contractor shall inform Providers that claims for services provided to Members during the month(s) in question may be paid by the DHCS fiscal intermediary, if the Member is determined eligible for the Medi-Cal program.

Upon request by Contractor, DHCS may allow Contractor to retain ~~the Capitation Payments made~~ **amounts paid to Contractor** for Members that are eligible to enroll in Contractor's ~~plan~~ **Medi-Cal Managed Care Health Plan**, but should have been retroactively disenrolled pursuant to Exhibit A, Attachment 11, Provision 18. Excluded Services Requiring Member Disenrollment, or under other

circumstances as approved by DHCS. ~~If Contractor retains the Capitation Payments,~~ **In such event,** Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Member, until the Member is disenrolled on a nonretroactive basis pursuant to Exhibit A, Attachment 16, Provision 3, Disenrollment.

B. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory Federal Medicaid requirements, the Federal Department of Health and Human Services (DHHS) may disallow Federal Financial Participation (FFP) for payments made by DHCS to Contractor. **In this event,** DHCS may recover the amounts disallowed by DHHS by an offset to ~~the Capitation Payments made to~~ Contractor**'s Revenues**. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHCS at its discretion may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months.

C. If DHCS determines that ~~any other erroneous or~~ **an** improper payment **was received by** ~~not mentioned above has been made to~~ Contractor **for any reason not referenced in Paragraph A or B, which may include, but is not limited to, error, mistake, omission, inadvertence, delay or neglect on the part of DHCS or other entity or person,** DHCS may recover the amounts determined by an offset to ~~the Capitation Payment made to~~ Contractor**'s Revenues**. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHCS, at its discretion, may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months. At least 30 calendar days prior to seeking any such recovery, DHCS shall notify Contractor to explain the improper or erroneous nature of the payment and to describe the recovery process. **DHCS may, at its discretion, withhold up to 100 percent of Contractor's Revenues for each month until any overpayment is fully recovered by the State**.

~~**12. Payment Of AIDS Beneficiary Rate**~~

~~A. Compensation at the AIDS Beneficiary Rate (ABR)~~

~~Subject to Contractor's compliance with the requirements contained in Subparagraph 1) below, Contractor shall be eligible to receive~~

~~compensation at the ABR for AIDS Beneficiaries. Compensation to Contractor at the ABR for each AIDS Beneficiary shall consist of payment at the ABR less the capitation rate initially paid for the AIDS Beneficiary.~~

~~1) Compensation at the ABR shall be subject to the conditions listed below. Contractor's failure to comply with any of the conditions listed below for any request for compensation at the ABR on behalf of an individual AIDS Beneficiary for a specific month of enrollment shall result in DHCS' denial of Contractor's claim for compensation at the ABR for that individual AIDS Beneficiary for that specific month of enrollment. Contractor may submit a corrected claim, within the timeframes specified in Paragraph d. below, that complies with all the conditions listed below and DHCS shall reimburse Contractor at the ABR.~~

~~a) The ABR shall be in lieu of any other compensation for an AIDS Beneficiary in any month.~~

~~b) For AIDS Beneficiaries, Contractor shall be eligible to receive compensation at the ABR commencing in the month in which a diagnosis of AIDS is made and recorded, dated and signed by the treating physician in the AIDS Beneficiary's Medical Record.~~

~~c) Contractor shall submit an invoice to DHCS by the 25th day of each month for claims for compensation at the ABR for AIDS Beneficiaries. The invoice shall include the following:~~

~~i. A list of all AIDS Beneficiaries identified by Medi-Cal numbers only for whom the Contractor is claiming compensation at the ABR. Member names shall not be used.~~

~~ii. The month(s) and year(s) for which compensation at the ABR is being claimed for each AIDS Beneficiary listed, sorted by month and year of service.~~

~~iii. The capitation rate initially paid for the AIDS Beneficiary for each month being claimed by the Contractor, the ABR being claimed, and the~~

~~difference between the ABR and the capitation rate initially paid for the AIDS Beneficiary.~~

~~iv. The total amount being claimed on the invoice.~~

~~d) Invoices, containing originally submitted claims or corrected claims, for compensation at the ABR for any month of eligibility during the rate year beginning April 1, 2005, and ending September 30, 2005, or any rate year thereafter beginning October 1 and ending September 30, must be submitted by Contractor to DHCS no later than six (6) months following the end of the subject rate year.~~

~~e) Invoices shall include the Agreement Number and shall be submitted to:~~

~~California Department of Health Care Services~~
~~Managed Care Operations Division~~
~~Attn: Fiscal Analysis Unit~~
~~Mailing Address: See Exhibit A, Scope of Work, Provision 4~~

~~In addition, invoices shall:~~

~~i. Be prepared on company letterhead.~~

~~ii. Bear the Contractor's name as shown on the agreement.~~

~~iii. Be signed by an authorized official, employee or agent.~~

~~2) Contractor shall confirm Medi-Cal eligibility of AIDS Beneficiaries prior to submission of the monthly invoice to DHCS. DHCS may verify the Medi-Cal eligibility of each Member for whom the ABR is claimed and adjust the invoiced amounts to reflect any capitation payments that have been previously made to Contractor for each Member prior to submission of the invoice required under Paragraph 1) c), above.~~

~~3) If DHCS determines that a Member for whom compensation has been paid at the ABR did not meet the definition of an AIDS Beneficiary, in a month for which the ABR was paid,~~

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~~DHCS shall recover any amount improperly paid, by an offset to Contractor's capitation payment, in accordance with Provision 11. Recovery of Capitation Payments, Paragraph C in this exhibit, DHCS shall give Contractor 30 calendar days prior written notice of any such offset.~~

~~B. Prompt Payment Clause~~

~~Payment will be made in accordance with, and within the time specified in, Chapter 4.5 (commencing with Section 927), Part 3, Division 3.6, of Title 2 of the Government Code.~~

~~C. Timely Submission of Final Invoice~~

~~1) A final undisputed ABR invoice shall be submitted for payment no more than 90 calendar days following the expiration or termination date of this Agreement, unless a later or alternate deadline is agreed to in writing by the program contract manager. Said ABR invoice should be clearly marked "Final Invoice - ABR", thus indicating that all payment obligations of the State under this Agreement have ceased and that no further payments are due or outstanding.~~

~~2) The State may, at its discretion, choose not to honor any delinquent final ABR invoice if the Contractor fails to obtain prior written State approval of an alternate final ABR invoice submission deadline. Written State approval shall be sought from the program contract manager prior to the expiration or termination date of this agreement.~~

~~3) The Contractor is hereby advised of its obligation to submit, with the final ABR invoice, a "Contractor's Release (Exhibit F)" acknowledging submission of the final ABR invoice to the State and certifying the approximate percentage amount, if any, of recycled products used in performance of this agreement.~~

1~~3~~2. Medical Loss Ratio (MLR)

The Medical Loss Ratio (MLR) as described in this Provision shall be done in accordance with 42 CFR 438.8, and shall be considered separate and distinct from the Adult Expansion Medical Loss Ratio (AE-MLR) and risk corridor as required in Exhibit B, Provision 14 of this Contract.

A. Beginning July 1, 2017, Contractor shall calculate and report a MLR as stated in 42 CFR 438.8 and 438.604(a)(3), in a form and manner specified by DHCS.

B. The MLR experienced by Contractor in a MLR Reporting Year is the ratio of the numerator, as stated in Paragraph C of this Provision, to the denominator, as stated in Paragraph D of this Provision. A MLR may be increased by a Credibility Adjustment, in accordance with Paragraph F of this Provision.

C. The numerator of Contractor's MLR for a MLR Reporting Year is the sum of Contractor's incurred claims, expenditures for activities that improve health care quality, and fraud prevention activities.

1) Contractor's Incurred Claims

a) Incurred claims must include the following:

i. Direct claims that Contractor paid to Providers, including under capitated contracts with Network Providers, for Covered Services or supplies under this Contract and meeting the requirements of 42 CFR 438.3(e).

ii. Unpaid claims liabilities for the MLR Reporting Year, including claims reported that are in the process of being adjusted or claims incurred but not reported.

iii. Withholds from payments made to Network Providers.

iv. Claims that are recoverable for anticipated coordination of benefits.

v. Claims payments recoveries received due to subrogation.

vi. Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.

vii. Changes in other claims-related reserves.

viii. Reserves for contingent benefits and the medical claim portion of lawsuits.

b) Amounts that must be deducted from incurred claims include the following:

   i. Overpayment recoveries received from Network Providers.

   ii. Prescription drug rebates received and accrued.

c) Expenditures that must be included in incurred claims include the following:

   i. The amount of incentive and bonus payments made, or expected to be made, to Network Providers.

   ii. The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in Section C, Paragraph 3 of this Provision.

d) Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to solvency funds mandated by DHCS.

e) The following amounts must be excluded from incurred claims.

   i. Non-Claims Costs, which include (1) the amounts paid to third-party vendors for secondary network savings; (2) amounts paid to third-party vendors for network development, administrative fees, claims processing, and UM; and (3) amounts paid for professional or administrative services, including amounts paid to a Provider, that do not represent compensation or reimbursement for California Medicaid State Plan services or services defined in 42 CFR 438.3(e) and provided to Members. Also included are fines and penalties assessed by regulatory authorities.

   ii. Amounts paid to Network Providers under 42 CFR 438.6(d).

f) Incurred claims paid by an entity that is later assumed by another entity must be reported by the assuming entity for the entire MLR Reporting Year and no incurred claims for that MLR Reporting Year may be reported by the ceding entity.

2) Activities that improve health care quality must be in one of the following categories:

a) Contractor activity that meets the requirements of 45 CFR 158.150(b) and is not excluded under 45 CFR 158.150(c).

b) Contractor activity related to any External Quality Review-related activity as described in 42 CFR 438.358(b) and (c).

c) Any Contractor expenditure that is related to health information technology and meaningful use, meets the requirements placed on issuers found in 45 CFR 158.151, and is not considered incurred claims, as defined in this Provision.

3) Contractor expenditures on activities related to fraud prevention as described in 45 CFR part 158, and not including expenses for fraud reduction efforts as stated in Section C, Paragraph 1.c) ii) of this Provision.

D. The denominator of Contractor's MLR for a MLR Reporting Year must equal the adjusted premium revenue. The adjusted premium revenue is Contractor's premium revenue minus Contractor's federal, state, and local taxes and licensing and regulatory fees, and is aggregated in accordance with this Provision.

1) Premium revenue includes the following for the MLR Reporting Year:

a) Capitation Payments, developed in accordance with 42 CFR 438.4, and excluding payments made per 42 CFR 438.6(d).

b) One-time payments for Member life events as specified in this Contract.

c) Other payments to Contractor approved under 42 CFR 438.6(b)(3).

d) All changes to unearned premium reserves.

e) Net payments or receipts related to risk sharing mechanisms developed in accordance with 42 CFR 438.5 or 438.6.

2) Taxes, licensing, and regulatory fees for the MLR Reporting Year shall include:

a) Statutory assessments to defray the operating expenses of any state or federal department.

b) Examination fees in lieu of premium taxes as specified by State law.

c) Federal taxes and assessments allocated to Contractor, excluding federal income taxes on investment income, capital gains, and federal employment taxes.

d) State and local taxes and assessments including:

i. Any industry-wide or subset assessments, other than surcharges on specific claims, paid to the State or a locality directly.

ii. Guaranty fund assessments.

iii. Assessments of state or local industrial boards or other boards for operating expenses, or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by the State.

iv. State or local income, excise, and business taxes, other than premium taxes and State employment and similar taxes and assessments.

v. State or local premium taxes, plus state or local taxes based on reserves, if in lieu of premium taxes.

e) Payments made by Contractor that are otherwise exempt from federal income taxes, for community benefit expenditures as defined in 45 CFR 158.162(c), limited to the highest of either:

i. Three percent (3%) of earned premium; or

ii. The highest premium tax rate in the State, multiplied

by Contractor's earned premium in the State.

3) If Contractor is later assumed by another entity that becomes the new Contractor under this Contract, the new Contractor must report the total amount of the denominator for the entire MLR Reporting Year, and no amount under this Paragraph for that year may be reported by the ceding Contractor.

E. In the allocation of expense, Contractor shall include each expense under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis. Contractor shall use the following methods to allocate expenses.

1) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.

2) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

3) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

F. Contractor may add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Partially Credible.

1) Contractor may not add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Fully Credible.

2) If a Contractor's experience is Non-Credible, it is presumed to meet or exceed the MLR calculation standards in this Provision.

3) Contractor shall fulfill these requirements by using the base credibility factors that CMS publishes annually in accordance with **42 CFR section** 438.8(h)(4).

G. Contractor shall aggregate data by Eligible Beneficiary groups identified in this Contract, or as otherwise directed by DHCS. This may require

separate reporting and MLR calculations for specific populations.

H. MLR Reporting requirements.

1) Contractor shall submit a report to DHCS that includes at least the following information for each MLR Reporting Year:

a) Total incurred claims.

b) Expenditures on quality improvement activities.

c) Expenditures related to activities compliant with 42 CFR 438.608(a)(1)-(5), (7), (8) and (b).

d) Non-Claims Costs.

e) Premium revenue.

f) Taxes, licensing, and regulatory fees.

g) Methodology(ies) for allocation of expenditures.

h) Any Credibility Adjustment applied.

i) The calculated MLR.

j) Any remittance owed to DHCS, if applicable.

k) A comparison of the information reported with the audited financial report required under 42 CFR 438.3(m).

l) A description of the method used to aggregate data.

m) The number of Member months.

2) Contractor must submit this report in a timeframe and manner determined by DHCS, but no longer than 12 months after the end of the MLR Reporting Year.

3) Contractor shall require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 days from the end of the MLR Reporting Year, or within 30 days of being requested by Contractor, whichever comes sooner, regardless of current

subcontracting limitations, to calculate and validate the accuracy of MLR reporting.

4) Contractor shall attest to the accuracy of the MLR calculation in accordance with requirements of this Provision when submitting the MLR report.

I. Contractor may be excluded from the requirements in this Provision in the first MLR Reporting Year of its operation. Contractor must then comply with these requirements beginning with the next MLR Reporting Year in which it contracts with DHCS, even if the first MLR Reporting Year was not a full 12 months.

J. In any instance where there is a retroactive change to the Capitation Payments for a MLR Reporting Year and the MLR report has already been submitted to DHCS, Contractor shall re-calculate the MLR for all MLR Reporting Years affected by the change and submit a new report meeting the reporting requirements in this Provision.

14 3 . Adult Expansion Risk Corridor

A. Establishment of an Adult Expansion Risk Corridor (AE Risk Corridor), based on an Adult Expansion Medical Loss Ratio (AE-MLR).

For Adult Expansion Members, DHCS shall make additional assumptions to the benefit of both the State and Contractor for this AE-Risk Corridor provision using an AE-MLR. DHCS shall perform AE-MLR calculations for the incurred periods stated below. Incurred dates align with the Net Capitation Payments and service dates of the Allowed Medical Expenses.

1) DHCS shall perform AE-MLR calculations for the incurred periods of January 1, 2014 to June 30, 2015, the first period, July 1, 2015 to June 30, 2016, the second period, July 1, 2016 to June 30, 2017, the third period, and July 1, 2017 to June 30, 2018, the fourth period.

2) For the first and second periods, DHCS or its designee will initiate the AE-MLR calculation no sooner than 12 months after the end of each incurred period. For the third period, DHCS or its designee will initiate the AE calculation no sooner than January 1, 2019. For the fourth period, DHCS or its designee will initiate the AE-MLR calculation on April 1, 2020.

3) DHCS will give consideration to paid claims data at least through June 30, 2016, for services incurred during the first period, at least through June 30, 2017, for the second period, at least through December 31, 2018, for the third period, and at least through March 31, 2020, for the fourth period.

4) Contractor shall provide and certify the AE Risk Corridor data and shall be subject to review or audit by DHCS or its designee.

a) For the fourth period, attestations will not be considered acceptable forms of documentation except when determined appropriate by DHCS in the following limited instances:

i. Attestations specific to the methodology used to calculate Excluded Federal Taxes and Assessments and Excluded State Taxes and Assessments, and

ii. Attestations specific to the classification of related and non-related party expenses.

b) All other attestations will be disallowed for this period. This documentation expectation does not impact the requirement for the managed care plan's Chief Executive Officer or Chief Financial Officer to certify data, documentation and information submitted for the AE Risk Corridor data is accurate, complete and truthful for the MLR period.

5) The AE Risk Corridor provision applies to this Contract only and will end with capitation and incurred dates as of June 30, 2018.

B. Adult Expansion Medical Loss Ratio (AE-MLR)

This Contract shall provide an AE-Risk Corridor pertaining to AE-MLR for Adult Expansion Members.

1) Contractor shall be required to expend at least 85 percent of Net Capitation Payments received on Allowed Medical Expenses for Adult Expansion Members, for each rating

region. If Contractor does not meet the minimum 85 percent AE-MLR threshold for a given rating region, then Contractor shall return to the State the difference between 85 percent of total Net Capitation Payments and actual Allowed Medical Expenses incurred for each rating region as directed by DHCS.

2) After completion of the AE-MLR calculation, if it is determined that Contractor's AE-MLR is less than 85 percent for a given rating region, then DHCS will notify Contractor of the Capitation Payments to be returned to the State.

3) Contractor shall remit to the State the full amount due within 90 calendar days of the date DHCS provides notice to Contractor of that amount.

4) Contractor protection is included for Allowed Medical Expenses above 95 percent of the total Net Capitation Payments received by Contractor for Adult Expansion Members, for each rating region.

   a) If Contractor's AE-MLR exceeds 95 percent for a given rating region, then DHCS shall make additional payment to Contractor.

   b) This additional payment from DHCS to Contractor will be the difference between Contractor's Allowed Medical
   Expenses and 95 percent of Net Capitation Payments received for that rating region.

   c) DHCS shall remit this payment to Contractor within 90 days of completion of this calculation, or within 90 days of approval to claim the additional federal funds, whichever is later.

5) If the AE-MLR is between 85 percent and 95 percent, then there will not be an AE Risk Corridor adjustment from Contractor to DHCS or from DHCS to Contractor.

C. Final Rates of Payment

For Adult Expansion Members, the actual payment rate for providing Covered Services under this Contract may differ from the rates initially included in this Contract, or the negotiated rate.

1) Actual payments may be adjusted if an adjustment is required subject to the provisions of this AE Risk Corridor methodology. Both Contractor and DHCS agree to accept the final payment levels that result from the AE Risk Corridor methodology calculation.

2) As a payment corridor, it is explicitly provided that this payment provision may result in payment by Contractor to DHCS or by DHCS to Contractor.

3) In the event of a change in capitation rate for Adult Expansion Members, for each period provided in this Provision, an AE Risk Corridor calculation in accordance with the requirements of this Provision shall be re-determined.

4) Subsequent to this re-determination, adjustments to payments in accordance with this Provision may result in changes in payment by Contractor to DHCS or by DHCS to Contractor.

D. AE Risk Corridor Disputes

Contractor shall have the opportunity to appeal a determination, through an appeal process defined by DHCS, that the 85 percent AE-MLR threshold has not been met and provide evidence that the required minimum has been met.

~~15~~ 4. Supplemental Payments

A. Contractor shall be entitled to ~~supplemental payments~~ **Supplemental Payments** stated within this Provision, based on the payment schedules identified within Exhibit B. Contractor must maintain on file evidence of payment for qualified services entitling them to ~~the supplemental payment~~ **Supplemental Payments**. Failure to have supporting records may, upon audit, result in recoupment by DHCS of ~~the supplemental payment~~ **Supplemental Payments**.

1) On a monthly basis, by the twentieth (20th) calendar day following the end of each month and in a format specified by DHCS, Contractor shall submit a report for ~~Medi-Cal Managed Care~~ Supplemental Payments. This report shall identify the Members receiving services qualifying for

~~supplemental payment~~ **Supplemental Payments** and for whom the payment amount is being claimed.

2) When Contractor receives and submits data to DHCS:

a) Within 14 months of the month of service, Contractor will receive the full ~~supplemental payment~~ **Supplemental Payment**.

b) After the fourteenth month following the month of service, Contractor will not receive a ~~supplemental payment~~ **Supplemental Payment**.

B. **Maternity** Supplemental ~~Maternity~~ Payment

1) Contractor shall be entitled to receive a **Maternity** Supplemental ~~Maternity~~ Payment for Members enrolled with Contractor on the date of the delivery of a child, including retroactive enrollments.

2) The **Maternity** Supplemental ~~Maternity~~ Payment reimburses Contractor for the **projected** cost of delivery **as determined by DHCS**~~, and is in addition to the monthly Capitation Rate paid by DHCS to Contractor for the Member~~.

C. **Supplemental Payments for** Hepatitis C Prescriptions

~~1)~~ Contractor shall be paid a monthly ~~supplemental payment~~ **Supplemental Payment** based on a weekly rate for each Member who receives prescriptions for **specific** Hepatitis C ~~(Hep C)~~ drugs **identified by DHCS**. Payments are based on the Member's utilization as reported by Contractor. ~~The payment period for health care services shall commence on July 1, 2014.~~

~~2) Contractor shall receive a supplemental payment for each Member who receives prescriptions for Hep C drugs in addition to the monthly Capitation Payment.~~

D. Supplemental ~~Rate~~ Payments for Partial Dual Eligible and Medi-Cal Only Members

1) Contractor shall receive a monthly ~~supplemental payment~~ **Supplemental Payment** for each Partial Dual Eligible Member and Medi-Cal Only Member who is identified as

being in one of the Member mix categories as described in this Provision.

2) Contractor shall receive a ~~supplemental payment~~ **Supplemental Payment** for each Partial Dual Eligible Member and Medi-Cal Only Member who meets the following criteria:

a) Institutional: Members who reside in a nursing facility for 90 days or more and are identified by Contractor in a file per Section C of this Provision. Exceptions will include Members with a LTC aid code as identified in Exhibit E, DEFINITIONS, Eligible Beneficiary.

b) HCBS High: Members who are at a high risk for institutionalization based on an IHSS classification of "Severely Impaired", or are in the MSSP 1915(c) Waiver, or are receiving CBAS as defined by Contractor.

~~c) HCBS Low: Members who have an IHSS classification of "Not Severely Impaired".~~

3) Supplemental ~~payments~~ **Payments** for Partial Dual Eligible and Medi-Cal Only Members shall be made in accordance with the existing schedule of Capitation Payment rates at the end of the month. Payments for Members identified as Institutional cannot exceed the rate as stated in this Provision and will be adjusted if DHCS has sent a separate rate payment for the Member for the same month of service. Payments for Members identified as HCBS High ~~or HCBS Low~~ will be made in addition to any other monthly rate payments sent for the Member for the same month of service.

E. Supplemental Payment for BHT Services

Contractor shall be paid a monthly ~~supplemental payment~~ **Supplemental Payments** for each Member who receives BHT services. Payments shall be based on the Member's utilization as reported by Contractor in accordance with the requirements in Exhibit B. The payment period for health care services shall commence on September 15, 2014.

16 5. Special Contract Provisions Related to Directed Payment Initiatives and Pass-Through Payment Programs

A. Contractor shall comply with the terms of each applicable Directed Payment Initiative approved by CMS under 42 CFR 438.6(c), in a form and manner specified by DHCS through All Plan Letters or other technical guidance. For applicable State Fiscal Years (SFY) or Rating Periods, commencing with SFY 2017-18, DHCS shall make the terms of each approved Directed Payment Initiative available on the DHCS website at www.dhcs.ca.gov.

B. Contractor shall comply with the terms of each applicable Pass-Through Payment established pursuant to 42 CFR 438.6(d) in accordance with the CMS approved rate certification, and in a form and manner specified by DHCS through All Plan Letter or other technical guidance.

16. Special Contract Provisions Related to Incentive Arrangements

Contractor shall comply with the terms of any Incentive Arrangements approved by CMS under 42 CFR 438.6(b)(2), in a form and manner specified by DHCS through All Plan Letters or other technical guidance. For applicable Rating Periods, commencing with the Rating Period starting July 1, 20190, DHCS shall make the terms of each approved Incentive Arrangement available on the DHCS website at www.dhcs.ca.gov.

17. Medicare Coordination

Pursuant to 42 CFR 438.3(t), Contractor shall enter into a Coordination of Benefits Agreement with the Medicare program through CMS, and agree to participate in Medicare's automated claims crossover process for Full Benefit Dual Eligible Members.

18. COVID-19 Risk Corridor

A. A risk-sharing arrangement shall be in effect for complete Rating Periods covering dates of services between July 1, 2019 and December 31, 2020, for those capitation increments, services and populations, as determined by DHCS.

1) The risk-sharing arrangement described in this Provision may result in payment by the State to Contractor or by Contractor to the State in a form and

manner specified by DHCS through All Plan Letters or other technical guidance.

2) The risk-sharing arrangement shall be symmetrical as to risk and profit and will be based on the results of a COVID-19 Risk Corridor calculation performed in a form and manner specified by DHCS through All Plan Letters or other technical guidance, aggregated across applicable Medi-Cal Managed Care Contracts between Contractor and the State for those capitation increments, services and populations, as determined by DHCS.

3) Contractor shall provide and certify allowable medical expense data necessary for the COVID-19 Risk Corridor calculation in a form and manner specified by the State. The data and any related substantiating documentation is subject to review and adjustment at the State's discretion in a form and manner specified by DHCS through All Plan Letters or other technical guidance, and may be subject to audit by the State or its designee.

4) The State or its designee will initiate the COVID-19 Risk Corridor calculation no sooner than 12 months after the end of the applicable Rating Period.

B. If DHCS determines that the continuation of the risk-sharing arrangement is actuarially appropriate and necessary to account for the impacts of the COVID-19 public health emergency, the COVID-19 Risk Corridor, as described in sub-paragraphs 1 through 4 of paragraph A above, shall continue to apply in a form and manner specified by DHCS through All Plan Letters or other technical guidance for Rating Periods starting on or after January 1, 2021.

XX. Exhibit E, Attachment 1, DEFINITIONS, is amended to read:

Adult Expansion Medical Loss Ratio (AE-MLR) means the Allowed Medical Expenses for the Covered Services provided to Adult Expansion Members under this Contract divided by the amount of Medi-Cal managed care Net Capitation Payments ~~or revenues~~ recorded by Contractor, by rating region. The AE-MLR will be measured by the same rating region that was used in the development of the capitation rates paid to Contractor, under this Contract.

A. For the first, second, and third periods, the calculation excludes both the portion of Contractor's capitation revenues and associated expenses for items such as intergovernmental transfers, Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments.

B. For the fourth period, the calculation excludes both the portion of Contractor's capitation revenues and associated expenses for items such as Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d).

If a Staff Model Contractor does not account for Allowed Medical Expenses specifically by line of business and uses an allocation methodology, the AE-MLR shall be the average AE-MLR of all other Medi-Cal Managed Care Health Plans operating within the rating region in which Contractor operates. In such cases, the Staff Model Contractor's AE-MLR shall be excluded from the average AE-MLR.

Adult Expansion Member means a Member enrolled in aid codes L1, M1, and 7U as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y). Expenditures for services provided to Adult Expansion Members qualify for the enhanced federal medical assistance percentage described in that section.

Affiliate means an organization or person that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control with the Contractor and that provides services to, or receives services from, the Contractor.

~~**AIDS Beneficiary** means a Member for whom a Diagnosis of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has been made by a treating physician based on the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention.~~

Allied Health Personnel means specially trained, licensed, or credentialed health workers other than physicians, podiatrists and nurses.

Allowed Medical Expenses means Contractor's expenses incurred and accounted for in accordance with Generally Accepted Accounting Principles (GAAP) for Covered Services delivered to Members during each period, including expenses incurred for utilization management and quality assurance activities, shared risk pools, incentive payments to Providers, payments required by Directed Payment Initiatives, and excluding administrative costs as defined in Title 28 CCR Section 1300.78.

A. For the first, second, and third periods, designated medical expense amounts included in the capitation rates that Contractor is required to pay Providers such as intergovernmental transfers, Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments, are excluded.

B. For the fourth period, designated medical expense amounts included in the capitation rates that Contractor is required to pay Providers such as Medi-Cal Managed Care Plan Taxes, Health Insurance Providers Fee (HIPF), Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d), are excluded.

~~B~~**C**. Global sub-capitation payments made by Contractor, where entire Allowed Medical Expenses are shifted to another entity, gross or net of utilization management or quality assurance, shall not exceed 95 percent, unless otherwise agreed by DHCS, of the Net Capitation Payment for consideration within Allowed Medical Expenses.

~~C~~**D**. Payments by Contractor to related party Providers shall not exceed the rate paid by Contractor for the same services to unrelated party Providers within the same rating region. Related parties are defined by GAAP.

All Plan Letter (APL) means a document that has been dated, numbered, and issued by DHCS that provides clarification of Contractor's obligations pursuant to this Contract, and may include instructions to Contractor regarding implementation of mandated changes in State or federal statutes or regulations, or pursuant to judicial interpretation.

American Indian means a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes membership in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

American Indian Health Service Programs means Facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible American Indian population within a defined geographic area, per Title 22, Section 55000.

Ambulatory Care means the type of health services that are provided on an outpatient basis.

Appeal means a review by Contractor of an adverse benefit determination, which includes one of the following actions:

A) A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service;

B) A reduction, suspension, or termination of a previously authorized service;

C) A denial, in whole or in part, of payment for a service;

D) Failure to provide services in a timely manner; or

E) Failure to act within the timeframes provided in 42 CFR 438.408(b).

Applied Behavioral Analysis (ABA) means the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior.

Autism Spectrum Disorder (ASD) means a developmental disability originating in the early development period and affecting social communication and behavior, which has been diagnosed in accordance with the Diagnostic and Statistical Manual, 5th Edition (DSM-5). ASD also includes diagnoses of Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specific (PDD-NOS), and Asperger Disorder that were made using DSM-IV criteria.

Auxiliary Aids mean supports that allow disabled Members to receive and understand information and include, but are not limited to, the use of TTY/TDD, Braille, large font of at least 18-point, and American Sign Language interpreters.

Basic Case Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

Behavioral Health Treatment (BHT) means Medically Necessary, evidence-based behavioral interventions to promote, to the maximum extent practicable, the functioning of a Member. These services are interventions designed to treat behavioral conditions as determined by a licensed physician, surgeon, or psychologist. BHT includes a variety of evidence-based behavioral interventions identified by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence that are designed to be delivered primarily in the home and in other community settings.

BHT Provider means a Qualified Autism Services (QAS) Provider, Professional, or Paraprofessional, as defined within the State Plan Amendment.

Beneficiary Assignment means the act of the California Department of Health Care Services (DHCS) or DHCS' enrollment contractor of notifying an Eligible Beneficiary in writing of the health plan in which the beneficiary shall be enrolled if the beneficiary fails to timely choose a health plan. If, at any time, the beneficiary notifies DHCS or DHCS' enrollment contractor of the beneficiary's health plan choice, such choice shall override the beneficiary assignment and be effective as provided in Exhibit A, Attachment 16, Provision 2.

Beneficiary Identification Card (BIC) means a permanent plastic card issued by the State to Medi-Cal recipients which is used by Contractors and Providers to verify Medi-Cal eligibility and health plan enrollment.

California Children's Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.

California Children's Services (CCS) Eligible Conditions means a physically handicapping condition defined in Title 22 CCR Section 41800.

California Children's Services (CCS) Program means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions.

Capitated Revenues means the amount of Medi-Cal managed care Capitation Payments/revenues paid to Contractor by DHCS for all Covered Services provided to Full Benefit Dual Eligible Members, or for MLTSS Covered Services and IHSS provided to Partial Dual Eligible Members and Medi-Cal Only Members, whichever is applicable, across all counties in which Contractor operates as a Medi-Cal Managed Care Health Plan.

Capitation Payment means a regularly scheduled payment made by DHCS to Contractor on behalf of each Member enrolled under this Contract and based on the actuarially sound capitation rate for the provision of Covered Services, and made regardless of whether a Member receives services during the period covered by the payment.

Care Coordination means services which are included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services,

Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.

Catastrophic Coverage Limitation means the date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness of or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to enrollment.

Claims and Eligibility Real-Time System (CERTS) means the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.

Clean Claim means a claim that can be processed without obtaining additional information form the Provider of the service or from a third party.

Cold-Call Marketing means any unsolicited personal contact by the Contractor with a potential Member for the purpose of marketing (as identified within the definition of Marketing).

Community Based Adult Services (CBAS) means an outpatient, facility based service program that delivers Skilled Nursing Care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services as defined in the Medi-Cal 2020 Waiver, to Members who meet applicable eligibility criteria.

CBAS Discharge Plan of Care means a **discharge** plan of care **based on the Member's CBAS assessment that is** prepared by the CBAS Provider ~~for Members who have been determined by Contractor or DHCS to no longer be eligible for CBAS~~ **pursuant to 22 C.C.R. § 78345 before the date of the Member's first reassessment, and reviewed and updated at the time of each reassessment and prior to discharge. The CBAS Discharge Plan of Care** and must include:

A. The Member's name and ID number

B. The name(s) of the Member's physician(s)

C. **If applicable, the** ~~D~~**d**ate the Notice of Action **denying authorization for CBAS** was issued

D. **If applicable, the** ~~D~~**d**ate the CBAS benefit will be terminated

E. Specific information about the Member's current medical condition, treatments, and medications

F. ~~A statement of how Enhanced Case Management services will be provided to the Member if eligible for these services~~ **Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge**

G. ~~A statement of the Member's right to file a Grievance or Appeal~~ **Contact information for the Member's case manager**

H. A space for the Member or the Member's representative to sign and date the Discharge Plan

CBAS Provider means an ADHC Center that provides CBAS to eligible Members and has been certified as a CBAS Provider by the California Department of Aging.

Complex Case Management means the systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.

Comprehensive Medical Case Management Services means services provided by a Primary Care Provider in collaboration with the Contractor to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for an Eligible Beneficiary. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

Confidential Information means specific facts or documents identified as "confidential" by any law, regulations or contractual language.

Contract means this written agreement between DHCS and Contractor.

Contracting Providers means a physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with Contractor to provide medical services to Members.

Corrective Actions means specific identifiable activities or undertakings of the Contractor which address program deficiencies or problems.

Cost Avoid means Contractor requires a Provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to Contractor paying the Provider for the services rendered.

County Department means the County Department of Social Services (DSS), or other county agency responsible for determining the initial and continued eligibility for the Medi-Cal program.

Covered Services means Medical Case Management and those services 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. Covered Services do not include:

A. Services for major organ transplants as specified in Exhibit A, Attachment 11, Provision 18.

B. Home and Community Based Services (HCBS) Waiver Program Services as specified in Exhibit A, Attachment 11, provisions 14 and 21 regarding Waiver Programs, and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver. *HCBS do not include any service that is available as an EPSDT service as described in Title 22 CCR ~~S~~**s***ections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A, Attachment 10 regarding Early and Periodic Screening, ~~Diagnosis~~ **Diagnostic** and Treatment (EPSDT) Services.*

C. California Children's Services (CCS) as specified in Exhibit A, Attachment 11, Provision 9.

D. Specialty Mental Health Services as specified in Exhibit A, Attachment 11, Provision 6.

E. Specialty Mental Health Services provided by psychiatrists; psychologists; licensed clinical social workers; or marriage, family, and child counselors.

F. Alcohol and substance use disorder treatment services and outpatient heroin detoxification as specified in Exhibit A, Attachment 11, Provision 7.

G. Fabrication of optical lenses as specified in Exhibit A, Attachment 10, Provision 8.

H. Directly observed therapy for treatment of tuberculosis as specified in Exhibit A, Attachment 11, Provision 16.

I. Dental services as specified in ~~Title 22 CCR Section 51307~~ **W & I Code sections 14132(h), 14131.10, 14132.22, 14132.23, and 14132.88,** and EPSDT ~~supplemental~~ dental services as described in Title 22 CCR Section 51340.1(~~a~~**b**). *However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment 11, Provision 15 regarding dental services.*

J. Chiropractic services as specified in Title 22 CCR Section 51308.

K. Prayer or spiritual healing as specified in Title 22 CCR Section 51312.

L. Local Education Agency (LEA) assessment services as specified in Title 22 CCR Section 51360(b) provided to a Member who qualifies for LEA services based on Title 22 CCR Section 51190.1.

M. Any LEA services as specified in Title 22 CCR Section 51360 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, Section 56340 et seq. or an Individualized Family Service Plan (IFSP) as set forth in Government Code Section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in Title 22 CCR Section 51360.

N. Laboratory services provided under the State serum alphafetoprotein-testing program administered by the Genetic Disease Branch of California Department of Public Health.

O. Pediatric Day Health Care.

P. Personal Care Services.

Q. State Supported Services.

R. Targeted case management services as specified in Title 22 CCR Sections 51185 and 51351, and as described in Exhibit A, Attachment 11, Provision 3. **However, if Members under the age of 21 are not eligible for or accepted by a Regional Center or a local government health program for TCM services, Contractor shall ensure access to comparable services under the EPSDT benefit in accordance with APL 19-010**.

S. Childhood lead poisoning case management provided by county health departments.

T. Psychotherapeutic drugs that are listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model, Capitated/Noncapitated Drugs section, which lists excluded psychiatric drugs.

U. Human Immunodeficiency Virus (HIV) and AIDS drugs that are listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model, Capitated/Noncapitated Drugs section, which lists excluded HIV/AIDS drugs.

V. Optional benefits as set forth in Welfare and Institutions Code Section 14131.10, as implemented by the Medi-Cal Fee-For-Service program.

W. Non-medical services provided by Regional Centers to individuals with developmental disabilities, including but not limited to, respite, out-of-home placement, and supportive living.

X. End of life services as stated in Health and Safety Code Section 443 et seq., and APL 16-006.

Credentialing means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

Credibility Adjustment means an adjustment to the MLR when Contractor is Partially Credible to account for a difference between the actual and target MLRs that may be due to random statistical variation.

Delivery means a live birth that generates a Vital Record for the State of California.

Department of Health and Human Services (DHHS) means the Federal agency responsible for management of the Medicaid program.

California Department of Health Care Services (DHCS) means the single State Department responsible for administration of the Federal Medicaid (referred to as Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

Department of Managed Health Care (DMHC) means the State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

~~**Diagnosis of AIDS** means a clinical diagnosis of AIDS that meets the most recent communicable disease surveillance case definition of AIDS established by the Federal Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services, (DHHS) and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements, in effect for the month in which the clinical diagnosis is made.~~

Dietitian/Nutritionist means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Business and Professions Code, Chapter 5.65, Sections 2585 and 2586).

Directed Payment Initiative means a payment arrangement approved by CMS described in 42 CFR 438.6(c) that directs certain expenditures made by Contractor under this Contract.

Director means the Director of the California Department of Health Care Services.

Discharge Planning means planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Disproportionate Share Hospital (DSH) means a health facility licensed pursuant to Health and Safety Code, Chapter 2, Division 2, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to Welfare and Institutions Code, Section 14105.98.

Durable Medical Equipment (DME) means Medically Necessary medical equipment that is prescribed for the Member by Provider and is used in the Member's home, in the community or in an institution that is used as a home.

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in Contractor's Service Area with one of the following aid codes:

Aid Group	*Mandatory Aid Codes*	*Non-Mandatory Aid Codes*
Adult & Family/Optional Targeted Low-Income Child	01, 02, 08, 0A, 0E, **2C (effective 10/1/2019),** 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 72, 7A, 7J, 7S, 7W, 7X, 82, 8P, 8R, E2, E5, K1, M3, M7, P5, P7, P9, 5C, 5D, E6, E7, H1, H2, H3, H4, H5, M5, T1, T2, T3, T4, T5	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 86, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K
Family/Dual Eligible	0E, 30, 32, 33, 34, 35, 37, 38, 39, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 72, 7A, 7J, 7W, 7X, 82, 8P, 8R, E2, E5, K1, M3, M7, P5, P7, P9	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K
SPD	10, 14, 16, 1E, 1H, 20, 24, 26, 2E, 2H, 36, 60, 64, 66,	

	6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, **L6**	
Adult Expansion	L1, M1, 7U	
Breast and Cervical Cancer Treatment Program (BCCTP)		0N, 0P, 0W
Long Term Care/Full Dual Eligible	13, 23, 63	
Long Term Care/ Non-Full Dual Eligible	13, 23, 63	
SPD/Dual Eligible	10, 14, 16, 17, 1E, 1H, 1X, 1Y, 20, 24, 26, 27, 2E, 2H, 36, 60, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6W, 6X, 6Y	

An Eligible Beneficiary may continue to be a Member following any redetermination of Medi-Cal eligibility that determines that the individual is eligible for, and the individual thereafter enrolls in, the BCCTP.

The following exclusions apply to all the above:

A. Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for any major organ transplant that is a Medi-Cal FFS benefit except kidney transplants.

B. Individuals who have commercial HMO coverage. Individuals with Medicare FFS coverage are not excluded from enrolling under this Contract.

Emergency Medical Condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

A. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

B. Serious impairment to bodily function.

C. Serious dysfunction of any bodily organ or part.

Emergency Medical Transportation means ambulance services for an Emergency Medical Condition, and includes emergency air transportation.

Emergency Services means covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish those services and that are needed to evaluate or stabilize an emergency medical condition.

Encounter means any single medically related service rendered by (a) medical Provider(s) to a Member enrolled with Contractor during the date of service. It includes, but is not limited to, all services for which Contractor incurred any financial liability.

Encounter Data means the information that describes health care interactions between Members and Providers relating to the receipt of any item(s) or service(s) by a Member under this contract and subject to the standards of 42 CFR 438.242 and 438.818.

~~**Enhanced Case Management (ECM)** means a service for Members who received ADHC services from July 1, 2011 through February 29, 2012 but were deemed ineligible for CBAS, consisting of Complex Case Management and Person-Centered Planning services including the coordination of eligible Medi-Cal beneficiaries' individual needs for the full array of necessary long-term services and supports including medical, social, educational, and other services, whether covered or not under the Medicaid program, and periodic in-person consultation with the Member and/or the Member's designees.~~

Enrollment means the process by which an Eligible Beneficiary becomes a Member of the Contractor's **Medi-Cal Managed Care Health** ~~p~~**P**lan.

Excluded Federal Taxes and Assessments means all federal taxes and assessments allocated to health insurance coverage, including but not limited to federal income taxes and the Patient Centered Outcomes Research Institute (PCORI) Fee.

Excluded Service means a service that is covered by the Medi-Cal program but is not covered by Contractor because it is carved out of Contractor's contractual obligations for the provision of Covered Services.

Excluded State Taxes and Assessments means:

A. Any industry-wide or subset assessments, other than surcharges on specific claims, paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State as applicable under this Contract;

B. Guaranty fund assessments;

C. Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or

similar taxes levied by the State;

D. State income, excise, and business taxes other than premium taxes;

E. State premium taxes plus State taxes based on policy reserves, if in lieu of premium taxes; and

F. Payments made by a Federal income tax exempt issuer for community benefit expenditures, to the extent allowed pursuant to 45 CFR 158.162(b)(1)(vii).

External Accountability Set (EAS) means a set of HEDIS® and DHCS-developed performance measures selected by DHCS for evaluation of health plan performance.

External Quality Review means an analysis and evaluation by the EQRO of aggregated information on quality, timeliness and access to the Covered Services that Contractor or its Subcontractors furnish to Members, as referenced for related activities in Exhibit A, Attachment 4 of this Contract.

External Quality Review Organization (EQRO) means a Peer Review Organization (PRO), PRO-like entity, or accrediting body that is an expert in the scientific review of the quality of health care provided to Medicaid beneficiaries in a state's Medicaid managed care plans, meets the competence and independence requirements set forth in 42 CFR 438.354, and is contracted with DHCS to perform External Quality Reviews and other related activities per 42 CFR 438.358.

Facility means any premise that is:

A. Owned, leased, used or operated directly or indirectly by or for Contractor or its affiliates for purposes related to this Contract, or

B. Maintained by a Provider to provide services on behalf of Contractor.

Federal Financial Participation means Federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.

Federally Qualified Health Center (FQHC) means an entity defined in Section 1905 of the Social Security Act (42 USC Section 1396d(l)(2)(B)).

Federally Qualified Health Maintenance Organization (FQHMO) means a prepaid health delivery plan that has fulfilled the requirements of the HMO Act, along with its amendments and regulations, and has obtained the Federal Government's qualification status under Section 1310(d) of the Public Health Service Act (42 USC Section 300e).

Fee-For-Service (FFS) means a method of payment based upon per unit or per procedure billing for services rendered to an Eligible Beneficiary.

Fee-For-Service Medi-Cal means the component of the Medi-Cal Program which Medi-Cal Providers are paid directly by the State for services not covered under this Contract.

Fee-For-Service Medi-Cal Mental Health Services (FFS/MC) means the services covered through Fee-For-Service Medi-Cal which includes mental health outpatient services and acute care inpatient services.

File and Use means a submission to DHCS that does not need review and approval prior to use or implementation, but which DHCS can require edits as determined.

Financial Performance Guarantee means cash or cash equivalents which are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which shall not be less than one full month's ~~c~~**C**apitation **Payment**.

Financial Statements means the Financial Statements which include a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles.

Fiscal Year (FY) means any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30, the Federal Fiscal Year is October 1 through September 30.

Full Benefit Dual Eligible Member means a Member who is 21 years of age or older, is eligible for Medi-Cal for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) and, Medicare Part B (42 U.S.C. Sec. 1395j et seq.), but who does not fall under any of the Adult Expansion aid codes..

Fully Credible means a standard, determined annually when CMS publishes base credibility factors specifying the number of Member months necessary for Contractor's experience to be to be deemed Fully Credible, where Contractor's experience is determined to be sufficient for the calculation of a MLR with a minimal chance that the difference between the actual and target MLR is not statistically significant. If Contractor's experience is Fully Credible, it will not receive a credibility adjustment to its MLR.

General and Administrative Expenses means expenses as defined in Title 28 CCR Section 1300.78. These expenses are not part of Allowed Medical Expenses, but are part of Net Capitation Payments.

Grievance means an oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the

right to dispute an extension of time proposed by Contractor to make an authorization decision.

Health Insurance Providers Fee (HIPF) means an annual fee starting in 2014 and paid by covered entities that provide health insurance for United States health risks during each year as described under Section 9010 of the Patient Protection and Affordable Care Act (Public Law 111-148), and as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Health Maintenance Organization (HMO) means an organization that is not a Federally qualified HMO, but meets the State Plan's definition of an HMO including the requirements under Section 1903(m)(2)(A)(i-vii) of the Social Security Act. An organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment.

Health Plan Employer Data and Information Set (HEDIS®) means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance.

HEDIS® Compliance Audit means an audit process that uses specific standards and guidelines for assessing the collection, storage, analysis, and reporting of HEDIS® measures. This audit process is designed to ensure accurate HEDIS® reporting.

Incentive Arrangement means any payment mechanism approved by CMS in accordance with 42 CFR section 438.6(b) under which Contractor may receive incentive payments in addition to Capitation Payments for meeting targets specified in accordance with the Contract.

Individualized Plan of Care (IPC) means a written plan designed to provide the Member determined to be eligible for CBAS with appropriate treatment in accordance with the assessed needs of the Member.

In-Home Support Services (IHSS) means services provided to Members by the County in accordance with the requirements set forth in W & I Code Section 14186.1(c)(1), and Article 7 of the W & I Code, commencing with Section 12300 of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.

Intermediate Care Facility (ICF) means a Facility which is licensed as an ICF by DHCS or a hospital or Skilled Nursing Facility which meets the standards specified in Title 22 CCR Section 51212 and has been certified by DHCS for participation in the Medi-Cal program.

Joint Commission on the Accreditation of Health Care Organizations (JCAHO) means the organization composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association. JCAHO provides health care accreditation and related services that support performance improvement in health care organizations.

Knox-Keene Health Care Service Plan Act of 1975 means the law that regulates HMOs and is administrated by the DMHC, commencing with, Health and Safety Code Section 1340.

Laboratory Testing Site means any laboratory and any Provider site, such as a PCP or Specialist office or clinic, that performs tests or examinations on human biological specimens derived from the human body.

Long-Term Care (LTC) means care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days.

Managed Long Term Services and Support (MLTSS) means services and supports provided by Contractor to Members who have functional limitations and/or chronic illnesses and which have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. In this Contract, MLTSS includes CBAS, LTC, MSSP, and SNFs, to the extent Contractor is at-risk for covering SNF services.

Marketing means any activity conducted by or on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade or influence Eligible Beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of the Contractor.

Marketing Materials means materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees.

Marketing Representative means a person who is engaged in Marketing activities on behalf of the Contractor.

Medi-Cal Eligibility Data System (MEDS) means the automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need beneficiary identification cards.

Medi-Cal Managed Care Health Plan means a managed care health plan that contracts with the Department of Health Care Services for provision or arrangement of Medi-Cal benefits and services.

Medi-Cal Managed Care Plan Taxes mean the extension of the State sales tax to sellers of Medi-Cal Managed Care plans for the privilege of selling Medi-Cal related health care services at retail in California as described under Revenue and Taxation Code Sections 6174 through 6189, and any successor State managed care organization provider tax applicable to Contractor.

Medi-Cal Only Member means a Member who is eligible for only Medi-Cal and receives CBAS, MSSP or LTC services from Contractor.

Medi-Cal Provider Manual means the multi-part document published and maintained by DHCS at http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp. The Manual includes program overviews, eligibility requirements, billing and claiming requirements, and instructions relating to specific programs and Provider types.

Medical Home means a place where a Member's medical information is maintained and care is accessible, continuous, comprehensive and culturally competent. A Medical Home shall include at a minimum: a Primary Care Physician (PCP) who provides continuous and comprehensive care; a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a Member; whole person orientation where the PCP is responsible for providing all of the Member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision support tools, and continuous quality improvement; ready access to assure timely preventive, acute and chronic illness treatment in the appropriate setting; and payment which is structured based on the value of the patient-centered medical home and to support care management, coordination of care, enhanced communication, access and quality measurement services. This definition can change to include all standards as set forth in W&I Code 14182(c)(13)(B).

Medical Loss Ratio (MLR) Reporting Year means a period of 12 months rating period established by DHCS.

Medical Records means written documentary evidence of treatments rendered to plan Members.

Medically Necessary or **Medical Necessity** means reasonable and necessary Covered Services to protect life, to prevent **significant** illness or **significant** disability, **or** alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, **as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to** achieve age-appropriate growth and development, and attain, maintain, or regain

functional capacity. ~~For Members receiving MLTSS, Medical Necessity shall be determined in accordance with Exhibit A, Attachment 21, Provision 7, Covered Services.~~

~~When determining the Medical Necessity of Covered Services for a Medi-Cal Member under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v).~~

For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. Contractor shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Member means any Eligible Beneficiary who has enrolled in the Contractor's plan. For the purposes of this Contract, "Enrollee" shall have the same meaning as "Member."

Member Evaluation Tool (MET) means the information collected from a Health Information Form (HIF), a high-level initial assessment completed by Members at the time of enrollment through which they may self-identify disabilities, acute and chronic health conditions, and transitional service needs. For newly enrolled SPD beneficiaries Contractor must use the MET as part of the health risk assessment process.

Minimum Performance Level refers to a minimum requirement of performance of Contractor on each of the External Accountability Set measures.

Minor Consent Services means those Covered Services of a sensitive nature which minors do not need parental consent to access, related to:

A. Sexual assault, including rape.

B. Drug or alcohol abuse for children 12 years of age or older.

C. Pregnancy.

D. Family planning.

E. Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.

F. Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or child abuse.

Multipurpose Senior Service Program (MSSP) means the Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver.

National Committee for Quality Assurance (NCQA) is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

NCQA Licensed Audit Organization is an entity licensed to provide auditors certified to conduct HEDIS Compliance Audits.

Net Capitation Payments means, for the first, second, and third periods, Contractor's capitation revenues less designated amounts included in capitation rates that Contractor is required to pay to Providers such as intergovernmental transfers, Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments. For the fourth period, Net Capitation Payments means Contractor's capitation revenues, including amounts related to Directed Payment Initiatives, less designated amounts included in capitation rates that Contractor is required to pay to Providers such as Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d). For all periods, Net Capitation Payments shall exclude retroactive adjustments relating to the prior service period(s) and shall include amounts accrued/recognized for the service period in accordance with GAAP.

Pass-Through Payment means a "pass-through payment" as defined in 42 CFR 438.6(a) that has been documented in a rate certification approved by CMS.

Qualified Autism Services (QAS) Provider means a licensed practitioner or Board Certified Behavior Analyst (BCBA).

QAS Professional means an Associate Behavioral Analyst, Behavior Analyst, Behavior Management Assistant, or Behavior Management Consultant, as defined in the State Plan Amendment, who provides Medically Necessary BHT services to Members.

QAS Paraprofessional means an individual who is employed and supervised by a QAS Provider to provide Medically Necessary BHT services to Members.

Rating Period means a period of time selected by DHCS for which actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS pursuant to 42 section CFR 438.7(a).

Revenue means the amount of Capitation Payments, Supplemental Payments, additional payments, and other revenue paid to Contractor by DHCS under this Contract.

Rural Health Clinic (RHC) means an entity defined in Title 22 CCR Section 51115.5.

Safety-Net Provider means any Provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the Provider. Examples of Safety-Net Providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; Rural and American Indian Health Service Programs; disproportionate share hospitals; and public, university, rural, and children's hospitals.

Seniors and Persons with Disabilities (SPD) means Medi-Cal beneficiaries who fall under specific SPD aid codes as defined by the department (See Eligible Beneficiary).

Service Area means the county or counties that the Contractor is approved to operate in under the terms of this Contract. A Service Area may have designated zip Codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this Contract.

Service Authorization Request means a Member's request for the provision of a Covered Service.

Service Location means any location at which a Member obtains any health care service provided by the Contractor under the terms of this Contract.

Significant Change means changes in Covered Services, benefits, the geographic Service Area, composition of payments to its Network, or enrollment of a new population, as stated in APL 18-XXX.

Skilled Nursing Care means Covered Services provided by licensed nurses, technicians, and/or therapists during a stay in a Skilled Nursing Facility or in a Member's home.

Skilled Nursing Facility (SNF) means, as defined in Title 22 CCR Section 51121(a), any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal

program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home," or "nursing facility."

Specialist means a Physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

Specialty Care Center means a center that is accredited or designated by the State or federal government, or by a voluntary national health organization, as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Specialty Mental Health Provider means a person or entity who is licensed, certified or otherwise recognized or authorized under State law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide Specialty Mental Health Services.

Specialty Mental Health Service means:

A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;

B. Psychiatric inpatient hospital services;

C. Targeted Case Management;

D. Psychiatrist services;

E. Psychologist services; and

F. EPSDT Specialty Mental Health Services.

Staff Model Contractor means a Health Maintenance Organization (HMO) that directly employs salaried Providers, and its Providers who only practice out of the HMO's buildings, and who may only provide services to its own Members.

Staff Model Providers means a Staff Model Contractor that has subcontracted with Contractor to provide Covered Services to Contractor's Members.

Standing Referral means a referral by a Primary Care Physician to a Specialist for more than one visit to the Specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

State means the State of California

State Supported Services means those services that are provided under a different contract between the Contractor and the Department.

Subacute Care means, as defined in Title 22 CCR Section 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed Skilled Nursing Care than is provided to the majority of patients in a SNF.

Subcontract means a written agreement entered into by the Contractor with any of the following:

A. A Provider of health care services who agrees to furnish Covered Services to Members.

B. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHCS under the terms of this Contract.

Subcontractor means an individual or entity who has a Subcontract with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract with DHCS.

Sub-Subcontractor means any party to an agreement with a Subcontractor descending from and subordinate to a Subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under this Contract.

Supplemental Payment means a payment, in addition to the Capitation Payment, made by DHCS to Contractor in accordance with Exhibit B, Provision 14 of this Contract, related to a specific instance, as defined by DHCS, of Contractor's provision of qualified Covered Services to a Member enrolled under this Contract.

XXI. Exhibit E, Attachment 2, PROGRAM TERMS AND CONDITIONS, is amended to read:

14. Termination for Cause or Other Terminations

In addition to Exhibit C, Provision 7. Termination for Cause, Contractor also agrees to the following:

A. Termination - State or Director

DHCS may terminate performance of work under this Contract in whole, or in part, whenever for any reason DHCS determines that the termination is in the best interest of the State.

1) Notification shall be given at least six (6) months prior to the effective date of termination, except in cases described below in Paragraph B. Termination for Cause.

2) If DHCS awards a new contract for one or more of the Service Areas to another Contractor during one of the amendment periods as described above in Provision 13. Contract Extension, DHCS shall provide the Contractor written notification at least six (6) months prior to termination to allow for all Phaseout Requirements to be completed.

B. Termination for Cause

1) DHCS shall terminate this Contract pursuant to the provisions of Welfare and Institutions Code, Section 14304(a) and Title 22 CCR Section 53873.

2) DHCS shall terminate this Contract in the event that: (1) the Secretary, DHHS, determines that the Contractor does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act (42 USC Section 1396), or (2) the Department of Managed Health Care finds that the Contractor no longer qualifies for licensure under the Knox-Keene Health Care Service Plan Act (Health and Safety Code Sections 1340 et seq.) by giving written notice to the Contractor. The termination will be effectuated consistent with the provisions of Title 22 CCR Section 53873. Notification will be given by DHCS at least 60 calendar days prior to the effective date of termination.

3) In cases where the Director determines the health and welfare of Members is jeopardized by continuation of the Contract, the Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination.

Except for termination pursuant to Paragraph B, item 3) above, Contractor may dispute the termination decision through the dispute resolution process pursuant to Provision 1~~8~~**7**, Disputes. Termination of the Contract shall be effective on the last day of the month in which the Secretary, DHHS, or the DMHC makes such determination, provided that DHCS provides Contractor with at least 60 calendar days' notice of termination. The termination of this Contract shall be effective on the last day of the second full month from the date of the notice of termination. Contractor agrees that 60 calendar days' notice is reasonable. Termination under this section does not relieve Contractor of its obligations under Provision 15. Phaseout Requirements below. Phaseout Requirements shall be performed after Contract termination.

C. Termination - Contractor

If mutual agreement between DHCS and Contractor cannot be attained on capitation rates for **Rating Periods** ~~rate years~~ subsequent to September 30, 2005, Contractor shall retain the right to terminate the Contract, no earlier than September 30, 2006, by giving at least six (6) months written notice to DHCS to that effect. The effective date of any termination under this section shall be September 30.

Grounds under which Contractor may terminate this Contract are limited to: (1) Unwillingness to accept the capitation rates determined by DHCS, or if DHCS decides to negotiate rates, failure to reach mutual agreement on rates; or (2) When a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which the Contractor entered into this Contract, such that the Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the term of the Contract.

If Contractor invokes ground number 2, Contractor shall submit a detailed written financial analysis to DHCS supporting its

conclusions that it cannot remain financially solvent. At the request of DHCS, Contractor shall submit or otherwise make conveniently available to DHCS, all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information required by DHCS to evaluate Contractor's financial analysis.

DHCS and Contractor may negotiate an earlier termination date if Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this section. Termination under these circumstances shall not relieve Contractor from performing the Phaseout Requirements described in Provision 15 below.

D. Termination of Obligations

All obligations to provide Covered Services under this Contract or Contract extension will automatically terminate on the date the Operations Period ends.

E. Notice to Members of Transfer of Care

At least 60 calendar days prior to the termination of the Contract, DHCS will notify Members about their medical benefits and available options.

15. Phaseout Requirements

A. DHCS shall retain the lesser of an amount equal to 10% of the last month's Service Area Capitation Payment or one million dollars ($1,000,000) for each Service Area unless provided otherwise by the Financial Performance Guarantee, from the Capitation Payment of the last month of the Operations Period for each Service Area until all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

If all Phaseout activities for each Service Area are completed by the end of the Phaseout Period, the withhold will be paid to the Contractor. If the Contractor fails to meet any requirement(s) by the end of the Phaseout Period for each Service Area, DHCS will deduct the costs of the remaining activities from the withhold

amount and continue to withhold payment until all activities are completed.

B. The objective of the Phaseout Period is to ensure that, at the termination of this Contract, the orderly transfer of necessary data and history records is made from the Contractor to DHCS or to a successor Contractor. The Contractor shall not provide services to Members during the Phaseout Period.

90 calendar days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area, the Contractor shall assist DHCS in the transition of Members and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Contractor will make available to DHCS copies of Medical Records, patient files, and any other pertinent information, including information maintained by any Subcontractor, necessary for efficient case management of Members, as determined by the Director. In no circumstances will a Medi-Cal Member be billed for this activity.

C. Phaseout for this Contract will consist of the processing, payment and monetary reconciliation(s) necessary regarding claims for payment for Covered Services.

Phaseout for this Contract will consist of the completion of all financial and reporting obligations of the Contractor. The Contractor will remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members pursuant to this Contract prior to the expiration or termination. The Contractor will submit to DHCS all reports required in Exhibit A, Attachment 17, Reporting Requirements, for the period from the last submitted report through the expiration or termination date.

All data and information provided by the Contractor will be accompanied by letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

D. Phaseout Period will commence on the date the Operations Period of the Contract or Contract extension ends. Phaseout related activities are non-payable items.

16. Sanctions

A. Contractor is subject to sanctions and civil penalties ~~taken pursuant to Welfare and Institutions Code Section 14304 and Title 22 of the California Code of Regulations, Section 53872, however, such sanctions and civil penalties may not exceed the amounts allowable under~~ **for the specific conduct set forth in** 42 CFR **sections 438.700, 438.702**, 438.704**, 438.706** and **438.708.** ~~as stated in APL 18-003. If required by DHCS, Contractor shall ensure Subcontractors cease specified activities which may include, but are not limited to, referrals, assignment of Members, and reporting, until DHCS determines that Contractor is again in compliance~~ **DHCS is also authorized to impose sanctions on Contractor pursuant to W&I Code section 14197.7**.

~~A~~ **B**. ~~In the event DHCS finds Contractor non-compliant with any provisions of this Contract, applicable statutes or regulations, DHCS may impose sanctions provided in Welfare and Institutions Code, Section 14304~~ **Monetary sanctions imposed pursuant to W&I Code section 14197.7** ~~and Title 22 CCR Section 53872 as modified for~~ **may be separately and independently assessed and may also be assessed for each day Contractor fails to correct an identified deficiency. For deficiencies that impact Members and Potential Enrollees, each Member impacted constitutes a separate violation for purposes of imposing a monetary sanction.** ~~purposes of this Contract. Title 22 CCR Section 53872 is so modified as follows~~:

1) ~~Subsection (b)(1) is modified by replacing "Article 2" with "Article 6"~~

2) ~~Subsection (b)(2) is modified by replacing "Article 3" with "Article 7"~~

~~B.~~ **C.** ~~The requirements of Exhibit A, Attachment 4, regarding QIS are all Contract provisions which are not specifically governed by Chapter 4.1 (commencing with Section 53800) of Division 3 of Title 22, CCR. Therefore, sanctions for violations of the requirements of Exhibit A, Attachment 4, regarding QIS shall be governed by Subsection 53872 (b)(4).~~ **Good cause for imposing monetary sanctions includes but is not limited to: A finding of deficiency that results in improper denial or delay in the delivery of health care services, potential endangerment to patient care, disruption in Contractor's Network, failure to approve**

continuity of care, claims that are accrued or will accrue and have not or will not be recompensed, or a delay in required Contractor reporting to DHCS.

~~C~~ **D**. ~~For purposes of Sanctions, good cause includes, but is not limited to, the following:~~ **The Director may identify findings of noncompliance or good cause through any means, including, but not limited to: findings in audits, investigations, and contract compliance reviews; quality improvement system monitoring, routine monitoring, and Facility site surveys; Encounter Data and Provider data submissions; Network adequacy reviews, assessments of timely access requirements, and reviews of utilization data; Medi-Cal Managed Care Health Plan rating systems; Grievance, Appeals, State Fair Hearing decisions, and complaints from Members and other stakeholders, and whistleblowers; and Contractor's self-disclosures. DHCS is not required to impose a corrective action plan before imposing any of the sanctions set forth in this Provision.**

~~1) Three (3) repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the medical audits conducted by DHCS.~~

~~2) In the case of Exhibit A, Attachment 4 Quality Improvement System, the Contractor consistently fails to achieve the minimum performance levels, or receives a "Not Reported" designation on an External Accountability Set measure, after implementation of Corrective Actions.~~

~~3) A substantial failure to provide Medically Necessary services required under this Contract or law to a Member.~~

~~4) Non-compliance with the Contract or applicable federal and State law or regulation.~~

~~5) Contractor has accrued claims that have not or will not be recompensed.~~

D. Sanctions in the form of denial of payments provided for under this Contract for new Members shall be taken, when and for as long as, payment for those Members is denied by the CMS under 42 CFR Section 438.730.

~~E. The Director shall have the power and authority to take one or more of the following sanctions against Contractor for noncompliance:~~

~~1) Appointment of temporary management if Contractor has repeatedly failed to meet the contractual requirements or applicable Federal and State law or regulation. Contractor cannot delay appointment of temporary management to provide a hearing before appointment. Temporary management will not be terminated until DHCS determines that Contractor's sanctioned behavior will not recur.~~

~~2) Suspension of all new enrollment, including default enrollment, or marketing activities after the effective date of the sanction;~~

~~3) Require Contractor to temporarily suspend or terminate personnel or Subcontractors.~~

~~4) Take other appropriate action as determined necessary by DHCS.~~

17. Liquidated Damages

A. General

The Director shall have the authority to impose liquidated damages on Contractor for failure to comply with the terms of this Contract as well as all applicable Federal and State law or regulation. Therefore, it is agreed by the State and Contractor that:

1) If Contractor does not provide or perform the requirements of this Contract or applicable laws and regulations, damage to the State shall result,

   a) Proving such damages shall be costly, difficult, and time-consuming,

   b) Should the State choose to impose liquidated damages, Contractor shall pay the State those damages for not providing or performing the specified requirements,

c) Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements,

d) The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the Contract,

e) DHCS may, at its discretion, offset liquidated damages from Capitation Payment owed to Contractor;

2) Imposition of liquidated damages as specified in Paragraphs B, Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, and C, Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period below shall follow the administrative processes described below.

3) Before imposing sanctions, DHCS shall provide Contractor with written notice specifying the nature of the sanctions and the Contractor requirement(s), contained in the Contract or as required by Federal and State law or regulation, not provided or performed,

4) During the Implementation Period, Contractor shall submit or complete the outstanding requirement(s) specified in the written notice within five (5) working days from the date of the notice, unless, subject to the Contracting Officer's written approval, Contractor submits a written request for an extension. The request must include the following: the requirement(s) requiring an extension; the reason for the delay and the proposed date of the submission of the requirement.

5) During the Implementation Period, if Contractor has not performed or completed an Implementation Period requirement or secured an extension for the submission of the outstanding requirement, DHCS may impose liquidated damages for the amount specified in Paragraph B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, below.

6) During the Operations Period, Contractor shall demonstrate the provision or performance of Contractor's requirement(s) specified in the written notice within a 30 calendar day Corrective Action period from the date of the notice, unless a request for an extension is submitted to the Contracting Officer, subject to DHCS' approval, within five (5) calendar days from the end of the Corrective Action period. If Contractor has not demonstrated the provision or performance of Contractor's requirement(s) specified in the written notice during the Corrective Action period, DHCS may impose liquidated damages for each day the specified Contractor's requirement is not performed or provided for the amount specified in Paragraph C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period, below.

7) During the Operations Period, if Contractor has not performed or provided Contractor's requirement(s) specified in the written notice or secured the written approval for an extension, after 30 calendar days from the first day of the imposition of liquidated damages, DHCS shall notify Contractor in writing of the increase of the liquidated damages to the amount specified in Paragraph C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period.

Nothing in this provision shall be construed as relieving Contractor from performing any other Contract duty not listed herein, nor is the State's right to enforce or to seek other remedies for failure to perform any other Contract duty hereby diminished.

B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, below.

DHCS may impose liquidated damages of $25,000 per requirement specified in the written notice for each day of the delay in completion or submission of Implementation Period requirements beyond the Implementation Period as specified in Provision 11. Term, above.

If DHCS determines that a delay or other non-performance was caused in part by the State, DHCS will reduce the liquidated damages proportionately.

C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period shall at a minimum include:

1) DHCS may impose liquidated damages of $2,500 per day for each violation of Contract requirement not performed in accordance with Exhibit A, Attachment 4, Quality Improvement System, provision 10. Site Review, Paragraph D. Corrective Actions, until Contract requirement is performed or provided.

2) DHCS may impose liquidated damages of $3,500 per instance or case, per Medi-Cal Member if a Contractor fails to deliver the requested information in accordance with Provision 23 Third-Party Tort Liability.

3) DHCS may impose liquidated damages of $3,500 per violation of Contract requirement not performed in accordance with Exhibit A, Attachment 6, Provider Network, Provision 9. Plan Physician Availability.

4) DHCS may impose liquidated damages not to exceed $10,000 per violation of this Contract's requirements, as well Federal and State law or regulation.

D. Conditions for Termination of Liquidated Damages

Except as waived by the Contracting Officer, no liquidated damages imposed on the Contractor will be terminated or suspended until the Contractor issues a written notice of correction to the Contracting Officer certifying, under penalty of perjury, the correction of condition(s) for which liquidated damages were imposed. Liquidated damages will cease on the day of the Contractor's certification only if subsequent verification of the correction by DHCS establishes that the correction has been made in the manner and at the time certified to by the Contractor.

The Contracting Officer will determine whether the necessary level of documentation has been submitted to verify corrections. The Contracting Officer will be the sole judge of the sufficiency and accuracy of any documentation. Corrections must be sustained for a reasonable period of at least 90 calendar days from DHCS

acceptance; otherwise, liquidated damages may be reimposed without a succeeding grace period within which to correct. The Contractor's use of resources to correct deficiencies will not be allowed to cause other Contract compliance problems.

E. Severability of Individual Liquidated Damages Clauses

If any portion of these liquidated damages provisions is determined to be unenforceable, the other portions will remain in full force and effect.

~~18. Disputes~~

~~In addition to Exhibit C, Provision 6. Disputes, Contractor also agrees to the following:~~

~~This Disputes section will be used by the Contractor as the means of seeking resolution of disputes on contractual issues.~~

~~Filing a dispute will not preclude DHCS from recouping the value of the amount in dispute from Contractor or from offsetting this amount from subsequent Capitation Payment(s). If the amount to be recouped exceeds 25 percent of the Capitation Payment, amounts of up to 25 percent will be withheld from successive Capitation Payment until the amount in dispute is fully recouped.~~

~~A. Disputes Resolution by Negotiation~~

~~DHCS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.~~

~~B. Notification of Dispute~~

~~Within 15 calendar days of the date the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the Contractor will notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.~~

~~The Contractor's notification will state, on the basis of the most accurate information then available to the Contractor, the following:~~

1) That it is a dispute pursuant to this section.

2) The date, nature, and circumstances of the conduct which is subject of the dispute.

3) The names, phone numbers, function, and activity of each Contractor, Subcontractor, DHCS/State official or employee involved in or knowledgeable about the conduct.

4) The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.

5) The reason the Contractor is disputing the conduct.

6) The cost impact to the Contractor directly attributable to the alleged conduct, if any.

7) The Contractor's desired remedy.

The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by the Contractor. This documentation will serve as the basis for any subsequent appeal.

Following submission of the required notification, with supporting documentation, the Contractor will comply with the requirements of Title 22 CCR Section 53851(d) and diligently continue performance of this Contract, including matters identified in the Notification of Dispute, to the maximum extent possible

C. Contracting Officer's or Alternate Dispute Officer's Decision

Pursuant to a request by Contractor, the Contracting Officer may provide for a dispute to be decided by an alternate dispute officer designated by DHCS, who is not the Contracting Officer and is not directly involved in the Medi-Cal Managed Care Program. Any disputes concerning performance of this Contract shall be decided by the Contracting Officer or the alternate dispute officer in a written decision stating the factual basis for the decision. Within 30

~~calendar days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer, shall either:~~

~~1) Find in favor of Contractor, in which case the Contracting Officer or alternate dispute officer may:~~

~~a) Countermand the earlier conduct which caused Contractor to file a dispute; or~~

~~b) Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment provisions contained in Exhibit B Budget Detail and Payment Provisions, direct DHCS to comply with that Exhibit.~~

~~Or,~~

~~2) Deny Contractor's dispute and, where necessary, direct the manner of future performance; or~~

~~3) Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise Contractor as to what additional information is required, and establish how that information shall be furnished. Contractor shall have 30 calendar days to respond to the Contracting Officer's or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer or alternate dispute officer shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the Contracting Officer or alternate dispute officer within the time period specified above shall constitute waiver by Contractor of all claims in accordance with Paragraph F. Waiver of Claims, below.~~

~~A copy of the decision shall be served on Contractor.~~

~~D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision~~

~~Contractor shall have 30 calendar days following the receipt of the decision to file an appeal of the decision to the Director. All appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1)~~

~~relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph B. Notification of Dispute above. Failure to timely appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with Paragraph F, Waiver of Claims below, Contractor shall exhaust all procedures provided for in this Provision 18, Disputes, prior to initiating any other action to enforce this Contract.~~

~~E. Contractor Duty to Perform~~

~~Pending final determination of any dispute hereunder, Contractor shall comply with the requirements of Title 22 CCR Section 53851 (d) and proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's or alternate dispute officer's decision.~~

~~If pursuant to an appeal under Paragraph D, Appeal of Contracting Officer's or Alternate Dispute Officer's Decision above, the Contracting Officer's or alternate dispute officer's decision is reversed, the effect of the decision pursuant to Paragraph D. shall be retroactive to the date of the Contracting Officer's or alternative dispute resolution decision, and Contractor shall promptly receive any benefits of such decision. DHCS shall not pay interest on any amounts paid pursuant to a Contracting Officer's or alternative dispute resolution decision or any appeal of such decision.~~

~~F. Waiver of Claims~~

~~If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this Provision 18, Disputes, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.~~

18. Contractor's Dispute Resolution Requirements

Contractor must comply with and exhaust the requirements of this section when it alleges a contract dispute with DHCS. This paragraph 18 does not apply to challenges to DHCS imposed sanctions, liquidated damages (which are governed by sections 16 and 17 respectively) or any other contract enforcement action initiated by DHCS. Contractor's filing of a Notice of Dispute, as defined in section B). 1) – 7) below, does not preclude DHCS from withholding or recouping the value of the amount in dispute from Contractor or from offsetting the amount in dispute from Contractor's Capitation Payment(s).

A. Resolution of Dispute by Negotiation

Contractor agrees to use its best efforts to resolve all alleged contractual disputes by negotiation and mutual agreement at the Contracting Officer level before filing an appeal with DHCS' Office of Administrative Hearings and Appeals (OAHA). Contractor must exhaust the OAHA appeal process before filing a writ in Sacramento Superior Court. During the negotiations to resolve Contractor's allegations, DHCS and Contractor may agree, in writing, to an extension of time for Contractor's submission of its Notice of Dispute defined in Section B.

B. Notice of Dispute

Within 30 calendar days of the date that the alleged dispute arises or otherwise becomes known to Contractor, Contractor must serve a written Notice of Dispute to its DHCS Contract Manager.

Contractor's Notice of Dispute must include, based on the most accurate information available to Contractor, the following:

1) That the dispute is subject to the procedures in this Provision.

2) The date, nature, and circumstances of the alleged conduct that is the subject of the dispute.

3) The names, phone numbers, functions, and conduct of each Contractor, Subcontractor, Network Provider,

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DHCS/State official or employee involved in or knowledgeable of the alleged conduct that is the subject of the dispute.

4) The identification of any documents and the substance of any oral communications that are relevant to the alleged dispute.

5) Copies of all substantiating documents and any other evidence to its Notice of Dispute.

6) The factual and legal bases prompting Contractor's Notice of Dispute.

7) The cost impact to Contractor directly attributable to the alleged conduct, if any.

8) Contractor's desired remedy.

Any appeal of the Contracting Officer's decision to OAHA or a writ seeking review of OAHA's decision in Sacramento Superior Court is limited to the issues set forth in Contractor's Notice of Dispute and the substantiating documentation provided pursuant to Paragraphs B, and C.3, below.

After Contractor submits its Notice of Dispute with all available supporting documentation, Contractor must comply with 22 CCR section 53851(d) and diligently continue performance of its obligations under this Contract, including compliance with contract requirements that are the subject of, or related to, Contractor's Notice of Dispute.

If Contractor requests and the Contracting Officer agrees, Contractor's Notice of Dispute may be decided by an alternate dispute officer (ADO) for determination. DHCS may designate the ADO, who was not directly involved in the alleged conduct that prompted Contractor's Notice of Dispute.

C. Contracting Officer's or Alternate Dispute Officer's Decision

The Contracting Officer or ADO will have 60 days to review Contractor's initial Notice of Dispute and all substantiating documentation. If the Contracting Officer or ADO determine that additional substantiating documentation is required, Contractor must provide that additional substantiating

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documentation no later than 30 calendar days from the request.

Unless Contractor and the Contracting Officer or ADO agree to an extension of time, Contractor's failure to provide additional substantiating documentation, within 30 calendar days from the request, constitutes Contractor's waiver of all claims set forth in Contractor's Notice of Dispute in accordance with F). Waiver of Claims, below.

Issues raised by Contractor in the Notice of Dispute will be decided by the Contracting Officer or the ADO Within 30 calendar days from receipt of all substantiating documentation and additionally requested substantiating documentation, the Contracting Officer or the ADO, will:

1) Find in favor of Contractor, in which case the Contracting Officer or ADO may:

   a) Correct the conduct which prompted Contractor's Notice of Dispute; or

   b) Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment provisions contained in Exhibit B Budget Detail and Payment Provisions, direct DHCS to comply with that Exhibit.

2) Deny Contractor's Notice of Dispute and, where necessary, direct the manner of Contractor's future contractual performance; or

3) The time limits in this subparagraph C may be extended by the Contracting Officer or Alternate Dispute Officer for up to 60 additional days upon request of Contractor and/or if it is necessary to allow the Contracting Officer or Alternate Dispute Officer to consider the dispute and/or substantiating documentation.

4) Contractor shall have 30 calendar days to respond to the Contracting Officer's or ADO's request for additional substantiating documentation and other necessary evidence. Upon receipt of this additional requested substantiating documentation, the Contracting Officer or ADO shall have 60 calendar days to respond with a

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decision. Contractor's failure to provide all additional substantiating documentation and other evidence requested by the Contracting Officer or ADO within 30 calendar days shall constitute waiver by Contractor of all claims in accordance with Paragraph F. Waiver of Claims, below.

D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

1. Contractor shall have 30 calendar days from receipt of Contracting Officer's or ADO's decision to appeal the decision to the Director through OAHA. All appeals shall be governed by Health and Safety Code Section 100171, except Government Code section 11511 relating to depositions will not apply. The venue for all OAHA appeals is Sacramento.

2. All appeals must be in writing and must be filed with OAHA with a copy sent to the Chief Counsel of DHCS and the Contract Manager. An appeal shall be deemed filed on the date it is received by OAHA. An appeal shall specifically set forth each issue in dispute, including Contractor's contentions as to each issue. However, Contractor's appeal is solely limited to the issues raised in its Notification of Dispute filed pursuant to Paragraph B. Notification of Dispute, above.

3. Contractor has the burdens of proof and its evidence is limited to the substantiating documentation it produced to the Contracting Officer or ADO. Contractor must show by a preponderance of evidence that:

a) DHCS acted improperly such that it breached this contract; and,

b) That Contractor sustained a cost impact directly related to DHCS' breach.

4. OAHA's jurisdiction is limited to issues raised in the Notice of Dispute that were not waived by Contractor's failure to provide all requested substantiating documentation required by the Contracting Officer's or ADO.

5. **Contractor's failure to timely appeal the decision to OAHA shall constitute a waiver by Contractor of all claims arising out of the alleged conduct that prompted Contractor's Notice of Dispute, in accordance with Paragraph F, Waiver of Claims below.**

E. Contractor's Duty to Perform

Contractor must comply with all requirements of 22 CCR section 53851(d) and all obligations under this Contract, including continuing contract obligations that are the subject of, or related to, Contractor's Notice of Dispute until there is a final decision from the Contracting Officer or the ADO.

If Contractor appeals the Contracting Officer's or ADO's decision pursuant to Paragraph D, Appeal of Contracting Officer's or ADO's Decision above, and Contracting Officer's or ADO's decision is reversed, DHCS shall not be required to pay interest on any underpayment found due and owing pursuant to the Notice of Dispute.

F. Waiver of Claims

Contractor waives all claims or issues if it fails to timely submit a Notice of Dispute with all substantiating documentation. Contractor also waives all claims or issues set forth in its Notice of Dispute if it fails to timely submit all additional substantiating documentation within 30 days of the Contracting Officer's or ADO's request, or if it fails to timely appeal the Contracting Officer's or ADO's decision in the manner and within the time specified in this Provision 18. Contractor's waiver includes all damages whether direct or consequential in nature.

19. Audit

In addition to Exhibit C, Provision 4, Audit, Contractor also agrees to the following:

Pursuant to 42 CFR 438.3(h), DHCS, CMS, the DHHS Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any of Contractor's, or its Subcontractors, records or documents and may, at any time, inspect the premises, physical facilities, and equipment where Medi-Cal-related activities or work is conducted. The right to audit under this Section exists for 10 years from

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the final date of the Contract period or from the date of completion of any audit, whichever is later.

The Contractor will maintain such records and documents necessary to disclose how the Contractor discharged its obligations under this Contract. These records and documents will disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which the Contractor administered its daily business, and the cost thereof.

A. Records and Documents

These records and documents will include, but are not limited to, all physical books or records originated or prepared pursuant to the performance under this Contract including working papers; reports submitted to DHCS; financial records; all medical records, medical charts and prescription files; and other documentation pertaining to medical and non-medical services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this Contract, Contractor and all of its Subcontractors shall maintain all of these records and documents for a minimum of ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later

C. Additional Recordkeeping Requirements

1) In accordance with 42 CFR 438.3(u), Contractor shall retain the following information for no less than 10 years:

a) Member Grievance and Appeal records as required in 42 CFR 438.416;

b) Base data as defined in 42 CFR 438.5(c);

c) MLR reports as required in 42 CFR 438.8(k); and

d) Data, information, and documentation specified in 42 CFR 438.604, 606, 608, and 610.

2) Contractor shall also require Subcontractors to be compliant, as applicable, with 42 CFR 438.3(u).

20. Inspection Rights

In addition to Exhibit D(F), Provision 2, Site Inspection, Contractor also agrees to the following:

Through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, Contractor shall allow the DHCS, the DHHS Office of the Inspector General, the Comptroller General of the United States, the DOJ Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives or designees, including DHCS' EQRO contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, facilities, contracts, computers, or other electronic systems maintained by Contractor and Subcontractors pertaining to these services at any time, pursuant to 42 CFR 438.3(h).

Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at Contractor's sole expense.

If DHCS, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit a Subcontractor at any time.

A. Facility Inspections

DHCS shall conduct unannounced validation reviews on a number of the Contractor's primary care sites, selected at DHCS' discretion, to verify compliance of these sites with DHCS requirements.

B. Access Requirements and State's Right to Monitor

Authorized State and federal agencies will have the right to monitor all aspects of the Contractor's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Contractor, Subcontractor, and Provider facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time, pursuant to 42 CFR 438.3(h). The monitoring activities will be either announced or unannounced.

To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Contractor. This will include the MIS operations site or such other place where duties under the Contract are being performed.

Staff designated by authorized State agencies will have access to all security areas and the Contractor will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Contractor and/or the Subcontractor(s).

21. Confidentiality of Information

In addition to Exhibit D(F), Provision 4, Confidentiality of Information, Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42 CFR Section 431.300 et seq., Section 14100.2, W&I Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by the Contractor from unauthorized disclosure.

Contractor may release ~~m~~**M**edical ~~r~~**R**ecords in accordance with applicable law pertaining to the release of this type of information.

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Contractor is not required to report requests for Medical Records made in accordance with applicable law.

B. With respect to any identifiable information concerning a Member under this Contract that is obtained by the Contractor or its Subcontractors, the Contractor: (1) will not use any such information for any purpose other than carrying out the express terms of this Contract, (2) will promptly transmit to DHCS all requests for disclosure of such information, except requests for Medical records in accordance with applicable law, (3) will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et seq., Section 14100.2, W & I Code, and regulations adopted thereunder, and (4) will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the Contractor by DHCS for this purpose.

22. Pilot Projects

DHCS may establish pilot projects to test alternative managed care models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect the Contractor's obligations under this Contract. Any changes in the obligations of the Contractor that are necessary for the operation of a pilot project in the Contractor's Service Area will be implemented through a contract amendment.

23. Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources (OHCS)

A. Contractor shall Cost Avoid or make a Post-Payment Recovery for the reasonable value of services paid for by Contractor and rendered to a Member whenever a Member's OHCS covers the same services, either fully or partially. However, in no event shall Contractor Cost Avoid or seek Post-Payment Recovery for the reasonable value of services from a Third-Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.

B. Contractor retains all monies recovered by Contractor.

C. Contractor shall coordinate benefits with other coverage programs or entitlements, recognizing the OHCS as primary and the Medi-Cal program as the payor of last resort.

D. Cost Avoidance

1) If Contractor reimburses the Provider on a FFS basis, Contractor shall not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third party coverage, designated by an OHC code or Medicare coverage, without proof that the Provider has first exhausted all sources of other payments. Contractor shall have written procedures implementing this requirement.

2) Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A or N.

E. Post-Payment Recovery

1) If Contractor reimburses the Provider on a FFS basis, Contractor shall pay the Provider's claim and then seek to recover the cost of the claim by billing the liable third parties:

a) For services provided to Members with OHC code A;

b) For services defined by DHCS as prenatal or preventive pediatric services; or

c) In child-support enforcement cases, identifiable by Contractor. If Contractor does not have access to sufficient information to determine whether or not the OHC coverage is the result of a child enforcement case, Contractor shall follow the procedures for Cost Avoidance.

2) In instances where Contractor does not reimburse the Provider on a FFS basis, Contractor shall pay for services provided to a Member whose eligibility record indicates third party coverage, designated by a OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual services rendered.

3) Contractor shall also bill the liable third parties for the cost of services provided to Members who are retroactively identified by Contractor or DHCS as having OHC.

4) Contractor shall have written procedures implementing the above requirements.

F. Reporting Requirements

1) Contractor shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A, Part B, and Part D. Reports shall be made available upon DHCS request.

2) When Contractor identifies OHC unknown to DHCS, Contractor shall report this information to DHCS within ten (10) calendar days of discovery in automated format as prescribed by DHCS. This information shall be sent to the California Department of Health Care Services, Third Party Liability Branch, Other Coverage Unit, P.O. Box 997422, Sacramento, CA 95899-7422.

3) Contractor shall demonstrate to DHCS that where Contractor does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Contractor projects it would receive from such activity

24. Third-Party Tort Liability

Contractor shall identify and notify DHCS' Third Party Liability Branch of all instances or cases in which Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code. Contractor shall make no claim for recovery of the value of Covered Services rendered to a Member in such cases or instances and such case or instance shall be referred to DHCS' Third Party Liability Branch within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

A. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an individual Member,

Contractor shall deliver the requested information within 30 calendar days of the request. Service information includes Subcontractor and Out-of-Network Provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted Providers or Out-of-Network Providers for similar services.

B. Information to be delivered shall contain the following data items:

1) Member name.

2) Full 14 digit Medi-Cal number.

3) Social Security Number.

4) Date of birth.

5) Contractor name.

6) Provider name (if different from Contractor).

7) Dates of service.

8) Diagnosis code and description of illness/injury.

9) Procedure code and/or description of services rendered.

10) Amount billed by a Subcontractor or Out-of-Network Provider to Contractor (if applicable).

11) Amount paid by other health insurance to Contractor or Subcontractor (if applicable).

12) Amounts and dates of claims paid by Contractor to Subcontractor or Out-of-Network Provider (if applicable).

13) Date of denial and reasons for denial of claims (if applicable).

14) Date of death (if applicable).

C. Contractor must include an attestation, signed by the custodian of records or a designee with knowledge of the

submitted service and utilization information and copies of paid invoices/claims. Contractor's attestation must comply with the requirements of the Third Party Liability Reporting Requirements APL 20-010,

~~C~~**D**. Contractor shall identify to DHCS' Third Party Liability Branch the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

~~D~~**E**. If Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of bills, Contractor shall refer the request to the Third Party Liability Branch with the information contained in Paragraph B above, and shall provide the name, address and telephone number of the requesting party.

~~E~~**F**. Information submitted to DHCS under this section shall be sent to the California Department of Health Care Services, Third Party Liability Branch, Recovery Section, MS 4720, P.O. Box 997425, Sacramento, CA 95899-7425.

25. Records Related To Recovery for Litigation

A. Records

Upon request by DHCS, Contractor shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Contractor's or its Subcontractors' possession, relating to threatened or pending litigation by or against DHCS. (If Contractor asserts that any requested documents are covered by a privilege, Contractor shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document.) Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Contractor acknowledges that time may be of the essence in responding to such request. Contractor shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by Contractor or its Subcontractors related to this Contract or Subcontracts entered into under this Contract.

B. Payment for Records

In addition to the payments provided for in Exhibit B, Budget Detail and Payment Provisions, DHCS agrees to pay Contractor for complying with Paragraph A, Records, above, as follows:

1) DHCS shall reimburse Contractor amounts paid by Contractor to third parties for services necessary to comply with Paragraph A. Any third party assisting Contractor with compliance with Paragraph A above, shall comply with all applicable confidentiality requirements. Amounts paid by Contractor to any third party for assisting Contractor in complying with Paragraph A, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by DHCS.

2) If Contractor uses existing personnel and resources to comply with Paragraph A, DHCS shall reimburse Contractor as specified below. Contractor shall maintain and provide to DHCS time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by DHCS.

   a) Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph A.

   b) Costs for copies of all documentation submitted to DHCS pursuant to Paragraph A, subject to a maximum reimbursement of ten (10) cents per copied page.

3) Contractor shall submit to DHCS all information needed by DHCS to determine reimbursement to Contractor under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

26. Fraud and Abuse Reporting

A. For purposes of this Exhibit, the following definitions apply:

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2 and as further defined in W. & I. Code Section 14043.1(a).)

Conviction or **Convicted** means that a judgment of conviction has been entered by a federal, State, or local court, regardless of whether an appeal from that judgment is pending (42 CFR 455.2). This definition also includes the definition of the term "convicted" in W & I Code Section 14043.1(f)**.**

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law (42 CFR 455.2; W. & I. Code Section 14043.1(i).)

Waste means the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit.

B. Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. These requirements shall be met through the following:

1) Contractor and its Subcontractor, to the extent that its Subcontractor is delegated responsibility by Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain procedures that are designed to detect and prevent Fraud, Waste, and Abuse. The procedures must include a compliance program, as set forth in 42 CFR 438.608(a), that at a minimum includes all of the following elements:

a) Written policies and procedures that articulate a commitment to comply with all applicable requirements and standards under this Contract, and all applicable federal and State requirements.

b) The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Contract, and who reports directly to the Chief Executive Officer and the Board of Directors.

c) The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the compliance program and compliance with the requirements under this Contract.

d) A system for training and educating the Compliance Officer, senior management, and employees on federal and State standards and requirements of this Contract.

e) Effective lines of communication between the Compliance Officer and employees.

f) Enforcement of standards through well-publicized disciplinary guidelines.

g) Establishment and implementation of a system with dedicated staff for: routine internal monitoring and auditing of compliance risks; promptly responding to compliance issues as they are raised; investigation of potential compliance problems as identified in the course of self-evaluation and audits; correction of such problems promptly and thoroughly, or coordination of suspected criminal acts with law enforcement agencies to reduce the potential for recurrence; and ongoing compliance with the requirements under this Contract.

2) Prompt reporting to DHCS of all Overpayments identified or recovered, specifying which Overpayments are due to potential fraud.

3) Prompt notification to DHCS when Contractor receives information about changes in a Member's circumstances

that may affect the Member's eligibility including the following:

a) Changes in the Member's residence;

b) Changes in the Member's income; and

c) The death of a Member.

4) Prompt notification to DHCS when Contractor receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the Medi-Cal managed care program, including the termination of their Provider agreement with Contractor.

5) Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Members, and the application of this verification processes on a regular basis.

6) When Contractor makes or receives annual payments under this Contract of at least $5,000,000, provide written policies for all of its employees, and for any Subcontractor or agent, that provides detailed information about the False Claims Act and other federal and State laws described in Section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

7) Fraud and Abuse Reporting

Prompt referral of any potential Fraud, Waste, or Abuse that Contractor identifies to the DHCS Audits and Investigations Intake Unit. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity.

Fraud reports submitted to DHCS must, at a minimum, include:

a) Number of complaints of fraud and abuse submitted that warranted preliminary investigation.

b) For each complaint which warranted a preliminary investigations, supply:

i. Name and/or SSN or CIN;

ii. Source of complaint;

iii. Type of Provider (if applicable);

iv. Nature of complaint;

v. Approximate dollars involved; and

vi. Legal and administrative disposition of the case.

The report shall be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

a) Email at PIUCases@DHCS.ca.gov;

b) E-fax at (916) 440-5287; or

c) U.S. Mail at:

Department of Health Care Services
Audits & Investigations Division
Attention: Chief, Intake Unit
1500 Capitol Avenue
MS 2500
Sacramento, CA 95814

Contractor shall submit the following components with the report or explain why the components are not submitted with the report: police report, health plan's documentation (background information, investigation report, interviews, and any additional investigative information), Member information (patient history chart, Patient profile, Claims detail report), Provider enrollment data, Confirmation of services, list items or services furnished by the Provider, Pharmaceutical data from manufacturers, wholesalers and retailers and any other pertinent information.

8) Tracking Suspended Providers

Contractor shall comply with 42 CFR 438.608(a)(8) and 438.610. Additionally, Contractor is prohibited from employing, paying, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (http://www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Medi-Cal Managed Care Program/Program Integrity Unit within 10 State working days of removing a suspended, excluded, or terminated provider from its Provider Network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. A removed, suspended, excluded, or terminated provider report can be sent to DHCS in one of three ways:

a) Email at PIUCases@DHCS.ca.gov;

b) E-fax at (916) 440-5287; or

c) U.S. Mail at:

Department of Health Care Services
Managed Care Operations Division
Attention: Chief, Program Integrity Unit
MS 4417
P.O. Box 997413
Sacramento, CA 95899-7413

C. Federal False Claim Act Compliance

Contractor shall comply with 42 USC Section 1396a(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Contract. Upon request by DHCS, Contractor shall demonstrate compliance with this Provision, which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

27. Equal Opportunity Employer

Contractor must comply with all applicable federal and State employment discrimination laws. Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of the Contractor's commitment as an equal opportunity employer and will post copies of the notice in conspicuous places available to employees and applicants for employment.

28. Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor shall not **unlawfully** discriminate against Members or Eligible Beneficiaries **on the basis of any ground protected under federal or state nondiscrimination law, including** because of **sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation,** ~~race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability,~~ or identification with any other persons or groups defined in Penal Code 422.56, in accordance with ~~Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations~~ **the statutes identified in Exhibit E, Attachment 2, Provision 28 below, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations**. For the purpose of this Contract, discrimination~~s on the grounds of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56~~ **may** include, but ~~are~~ **is** not limited to, the following:

1) Denying any Member any Covered Services or availability of a Facility;

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2) Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;

4) Restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;

5) The assignment of times or places for the provision of services on the basis of the **sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation** ~~race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability,~~ or identification with any other persons or groups defined in Penal Code 422.56, of the participants to be served~~.~~**;**

6) Failing to make Auxiliary Aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability;

7) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and Potential Enrollees.

Contractor shall take affirmative action to ensure that Members are provided Covered Services without regard to **sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation,** ~~race, color, national origin, creed,~~

~~ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability,~~ or identification with any other persons or groups defined in Penal Code 422.56, except ~~where~~ **as needed to provide equal access to LEP Members or Members with disabilities, or as** medically indicated. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related To Health Status

Contractor shall not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during enrollment, re-enrollment or disenrollment. Contractor will not terminate the enrollment of an eligible individual based on an adverse change in the Member's health.

~~C. Discrimination Complaints~~

~~Contractor agrees that copies of all Grievances alleging discrimination against Members or Eligible Beneficiaries because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, will be forwarded to DHCS for review and appropriate action.~~

29. Federal and State Nondiscrimination Requirements

Contractor shall comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; **Titles I and II of** the Americans with Disabilities Act of 1990, as amended; ~~and~~ Section 1557 of the Patient Protection and Affordable Care Act **of 2010; and federal implementing regulations issued under the above-listed statutes. Contractor shall also comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, Government Code sections 7405 and 11135, W&I Code section 14029.91, and state implementing regulations**.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

11. Consider Selection and Award of Contract for Vision Services Vendor

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

Authorize CalOptima's Chief Executive Officer:

1. With the assistance of Legal Counsel, to enter into a new three year agreement with Vision Service Plan for Medi-Cal, OneCare, OneCare Connect, and Program of All-Inclusive Care for the Elderly (PACE) members effective July 1, 2021 through June 30, 2024, along with two additional one-year extension options, each exercisable at CalOptima's sole discretion; and
2. To exercise one or both of the one-year extension options depending on CalOptima's business needs and vendor performance.

Background

Vision services are a required benefit for CalOptima's Medi-Cal, OneCare, OneCare Connect, and PACE members. Vision Service Plan (VSP) has been the vision services vendor for CalOptima since October 1998, as selected through competitive procurement processes. On each subsequent occasion, the CalOptima Board of Directors (Board) authorized the contract with VSP. Contracts have typically been for a three (3) year term, with two (2) one-year extension options. The Board has also authorized all extension options to date. The most recent extension ends June 30, 2021. Therefore, CalOptima staff issued another Request for Proposal (RFP) for a vision service vendor in October 2020.

Discussion

During the most recent RFP process, CalOptima received interest from a few vision services providers, with VSP being the only qualified respondent to satisfy all solicitation criteria. This includes the ability to perform all contract components, years of industry experience, licensure, and capacity to handle CalOptima's member population. The proposed new base contract term begins July 1, 2021 and extends through June 30, 2024. This Contract may be renewed at CalOptima's option for two additional one-year periods. VSP has a solid track record of providing quality vision services to CalOptima members over the last twenty years; therefore, staff recommends awarding the new vision services contract to VSP, as well as authority to exercise contract extensions as appropriate.

Fiscal Impact

Funding for the recommended action to enter into a new agreement with VSP for Medi-Cal, OneCare, OneCare Connect and PACE members effective July 1, 2021, will be included in the CalOptima Fiscal Year (FY) 2021-22 Operating Budget and future operating budgets.

Rationale for Recommendation

Based on CalOptima's prior history with this vendor, as well as a review of the vendor's RFP response and substantial experience, CalOptima staff considers VSP to be a qualified vision services vendor that

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is able to meet CalOptima's needs and ensure that all Members continue to have access to quality vision care delivered in a cost-effective manner.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Previous Board Action dated April 2, 2020; "Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts and Contracts with MedImpact Healthcare Systems, Inc. and Vision Service Plan"
3. Previous Board Action dated April 4, 2019; "Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts that Expire During Fiscal Year 2019-20"
4. Previous Board Action dated April 7, 2016; "Consider Selection of Vision Vendor and Authorize Contract for Vision Services Effective July 1, 2016"
5. Previous Board Action dated September 3, 2015; "Authorize Request for Proposal Process for Vision Service Vendor(s) Effective July 1, 2016 for Medi-Cal, OneCare, OneCare Connect, and PACE Programs"

/s/ Richard Sanchez — *01/27/2021*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Vision Service Plan (VSP)	3333 Quality Drive	Rancho Cordova	CA	92602

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

21. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts and Contracts with MedImpact Healthcare Systems, Inc. and Vision Service Plan

Contact

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

Recommended Action(s)

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE ancillary services contracts and contracts with ~~MedImpact Healthcare Systems, Inc. (MedImpact) and~~ Vision Service Plan (VSP), through June 30, 2021 under the same terms and conditions | Amended 4/2/2020

Background/Discussion

CalOptima currently contracts with many ancillary providers to provide health care services on a fee-for-service (FFS) basis to CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Members. Ancillary services include, but are not limited to, laboratory, imaging, durable medical equipment, home health, and transportation. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon Board approval. CalOptima also contracts on a capitated administrative fee basis (with the administrator passing the medical costs through to CalOptima on a FFS basis) with MedImpact ~~for~~ for Pharmacy Benefit Management (PBM) services, and with VSP for vision-related services.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the CalOptima Board of Directors.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE Ancillary contracts, and contracts with MedImpact and VSP, through June 30, 2021.

The renewal of these contracts with existing providers will support the stability of CalOptima's contracted ancillary provider network. Contract language does not guarantee any provider volume or exclusivity and allows for CalOptima and the providers to terminate the contracts with or without cause.

Fiscal Impact

The recommended action to extend CalOptima ancillary contracts through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

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Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the ancillary provider network and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action Dated February 6, 2020; Consider Ratification of Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager Services
2. Board Action Dated August 1, 2019; Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc.to Extend the Contract

/s/ Michael Schrader *03/26/2020*

Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action
Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion
At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

9/26/2018 — **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Ratification of an Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager Services

Contact
Kristin Gericke, Director, Clinical Pharmacy Management (714) 246-8400
Michelle Laughlin, Executive Director, Provider Network Operations (714) 246-8400

Recommended Action
Ratify Amendment to CalOptima's contract with MedImpact for Pharmacy Benefit Manager (PBM) Services, to revise prescription drug rebate provisions for CalOptima's Medi-Cal line of business.

Background
On May 7, 2015, the CalOptima Board of Directors (Board) authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options.

On October 4, 2018, the Board authorized an amendment to the PBM agreement by exercising CalOptima's first one-year extension option through December 31, 2019.

On February 7, 2019, the Board ratified revisions to the PBM agreement to include the collection of prescription drug rebates for CalOptima's Medi-Cal program.

More recently, on August 1, 2019, the Board authorized an amendment to the PBM agreement to extend the term through December 31, 2021.

Discussion
Pursuant to the primary agreement with the California Department of Health Care Services (DHCS), CalOptima had participated in the State Pharmacy Rebate program by submitting all pharmacy claims to DHCS on a monthly basis. DHCS, in turn, had managed collection of pharmacy rebates on an aggregate basis for all County Organized Health System (COHS) plans statewide.

With the passage of the Patient Protection and Affordable Care Act (ACA) on March 23, 2010, Medi-Cal managed care organizations became eligible to collect drug rebates for covered outpatient drugs dispensed to Medi-Cal members. The ACA made drug rebates applicable to both pharmacy-dispensed outpatient drugs and physician administered drugs. In addition, California statutory language restricting the COHS plans' ability to negotiate supplemental rebates with drug manufacturers was also removed via enactment of Senate Bill (SB) 870 on June 20, 2014, enabling COHS plans to negotiate rebates with drug manufacturers.

During its rate development meeting on October 25, 2018, DHCS informed CalOptima that the collection of prescription drug rebates by Medi-Cal managed care plans had gone from being optional to

mandatory, and instructed CalOptima to make commensurate adjustments to its reported cost data to DHCS.

As such, CalOptima, together with MedImpact, developed a contract amendment to implement a prescription drug rebate program. The contract amendment provided rebates per paid claims. This payment rate includes rebate management services and increases the amount to $4.50 per paid claim. Although the amendment, effective June 1, 2019, included provisions for collection of prescription drug rebates for all paid claims, CalOptima was subsequently informed by MedImpact that, for the Medi-Cal line of business, rebates are only applicable to claims for diabetic test strips and those drugs for which a manufacturers' rebate is available.

Staff therefore subsequently amended CalOptima's agreement with MedImpact to clarify that, effective October 1, 2018, rebates will only apply to Medi-Cal claims for diabetic test strips and medications that qualify for a manufacturers' rebate (i.e., MedImpact pays CalOptima a minimum rebate guarantee of $4.50 per claim only for claims for diabetic test strips and those drugs for which a manufacturers' rebate is available—not for all Medi-Cal medications). The projected amount of rebate dollars collected is also being revised pursuant to this change to include only those claims.

Staff seeks ratification of this amendment to the MedImpact PBM contract effective June 1, 2019, to include updated language clarifying which claims are eligible for rebates.

Fiscal Impact

The recommended action to ratify an amendment to CalOptima's contract with MedImpact for PBM services clarifies that the prescription drug rebate provisions for the Medi-Cal line of business is not expected to have an additional fiscal impact on the CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019. Staff projects approximately $1.8 million for FY 2018-19 and $3.2 million for FY 2019-20 in prescription drug rebates.

Generally, revenue from rebates would decrease prescription drug costs in the short term, but such cost savings would be offset by a commensurate decrease in future Medi-Cal revenue. With the Governor's Executive Order N-01-019 to transition most Medi-Cal pharmacy services from managed care to fee-for-service (FFS) by January 1, 2021, DHCS is expected to adjust CalOptima's Medi-Cal revenue for pharmacy services accordingly in the future. While pharmacy services remain a managed care benefit, Staff plans to include PBM fees and potential rebates in future operating budgets. In addition, Staff will monitor pharmacy expenses and rebates prior to and during the transition period to Medi-Cal FFS.

Rationale for Recommendation

The above recommendation will provide clarification regarding applicability of rebates under CalOptima's MedImpact agreement.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entity Covered by this Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services
4. Board Action dated February 7, 2019, Consider Ratification of Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager Services
5. Board Action dated August 1, 2019, Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract

/s/ Michael Schrader *01/28/2020*
Authorized Signature **Date**

Attachment to February 6, 2020 Board of Directors Meeting – Agenda Item 10

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems, Inc.	10181 Scripts Gateway Court	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
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Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action

Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

9/26/2018 — **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
7. Consider Ratification of Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager Services

Contact
Kristin Gericke, Director, Pharmacy Management, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action
Ratify amendment of CalOptima's contract with MedImpact for Pharmacy Benefit Manager (PBM) Services to begin collecting Medi-Cal prescription drug rebates for utilization incurred effective October 1, 2018.

Background
At its May 7, 2015 meeting, the CalOptima Board of Directors (Board) authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options.

On October 4, 2018, the Board ratified extending the PBM agreement by exercising CalOptima's first one-year extension option through December 31, 2019. Under the provisions in the PBM agreement, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. In addition, MedImpact handles rebates for CalOptima's OneCare and OneCare Connect programs. However, CalOptima's agreement with MedImpact does not currently include the collection of prescription drug rebates for CalOptima's Medi-Cal program.

Discussion
Pursuant to the primary agreement with the California Department of Health Care Services (DHCS), CalOptima has participated in the State Pharmacy Rebate program by submitting all pharmacy claims to DHCS on a monthly basis. DHCS, in turn, has managed collection of pharmacy rebates on an aggregate basis for all County Organized Health System (COHS) plans statewide. Initially, the rebate program was implemented when the majority of Medi-Cal enrollees were in Fee-For-Service (FFS) arrangements, and DHCS was able to execute substantial rebate agreements with drug manufacturers for Medi-Cal covered drugs. The understanding was that COHS plans would not execute such agreements for drugs on the Medi-Cal Contract Drug List (CDL), so that DHCS could claim rebates for the drug products listed on the CDL and utilized by the COHS plans.

With the passage of the Patient Protection and Affordable Care Act (ACA) on March 23, 2010, Medi-Cal managed care organizations became eligible to collect drug rebates for covered outpatient drugs dispensed to Medi-Cal members. The ACA made drug rebates eligible for both pharmacy-dispensed outpatient drugs and physician administered drugs. In addition, California statutory language restricting the COHS plans' ability to negotiate supplemental rebates with drug manufacturers was

removed by the enactment of Senate Bill (SB) 870 on June 20, 2014. The bill enabled COHS plans to negotiate rebates with drug manufacturers, with the understanding that DHCS will continue to submit plans' utilization when invoicing their supplemental contracts with drug manufacturers. In November 2015, DHCS sent additional guidance clarifying that:

> "if a COHS plan chooses to contract for medications currently contracted for by DHCS and listed on the CDL, they may do so…However, if a COHS plan successfully negotiates a supplemental rebate agreement with a drug manufacturer, then the Plan must notify DHCS and the department can no longer use the utilization for that drug (or drugs) when invoicing the manufacturers."

However, guidance provided by DHCS addressing the timeframe to implement SB 870 remained ambiguous. Language in the guidance stated:

> "the language that has always been in effect remains in effect for the time being…It will not become operational until the department officially implements the contracts applicable to both FFS and managed care drug formularies…That will not happen for quite some time."

As such, Medi-Cal managed care plans were aware of their eligibility to begin collecting rebates, but were uncertain when to begin implementation of such actions. Given this uncertainty, Management opted to maintain the existing operational procedures, whereby DHCS continued to collect drug rebates at the state level, until additional direction was given by the State.

At the rate development meeting on October 25, 2018, DHCS informed CalOptima that the collection of prescription drug rebates by Medi-Cal managed care plans was no longer optional, but required, and instructed CalOptima to make commensurate adjustments to their reported cost data to DHCS. By collecting rebates, plans will reduce their prescription drug costs by the amount of the rebates. However, savings to a plan's prescription drug expenses would be offset by a commensurate reduction in state revenue to the plan, since DHCS employs a cost-based methodology to develop a managed care plan's capitation rates.

As such, CalOptima began working with MedImpact on a contract amendment to implement a prescription drug rebate program. Staff has come to agreement with MedImpact on rates and contract terms and is working on a contract amendment to incorporate Medi-Cal prescription drugs within the existing rebate program already covered by the CalOptima-MedImpact agreement. The contract amendment replaces Exhibit B "Fee Schedule" with a guaranteed rebate per paid claim. This payment rate includes rebate management services, and increases to $4.50 per paid claim for Claim Years 4 and 5. Upon receiving Board authorization, Staff anticipates the collection of rebates to begin one hundred twenty (120) days after the end of the preceding quarter, for utilization incurred effective October 1, 2018, and thereafter until such time as the state provides the COHS plans with additional guidance on the Medi-Cal prescription drug benefit.

Fiscal Impact

The recommended action to amend CalOptima's contract with MedImpact for PBM services to collect prescription drug rebates for utilization incurred October 1, 2018, and after is projected to generate

$20.6 million in rebate dollars in Fiscal Year 2018-19, and $27.5 million on an annual basis. While the rebates effectively serve to decrease prescription drug costs, Staff anticipates that the cost savings will be offset by a commensurate decrease in future Medi-Cal revenue.

Rationale for Recommendation

The recommended action will allow CalOptima to comply with the DHCS's requirement for Medicaid managed care plans to collect prescription drug rebates.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Contracted Entity Covered by this Recommended Board Action

/s/ Michael Schrader — *1/30/2019*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems, Inc.	10181 Scripts Gateway Court	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action
Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion
At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

9/26/2018 — **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
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Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

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Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

19. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts that Expire During Fiscal Year 2019-20

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE ancillary services provider contracts through June 30, 2020, retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Amend these contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and make applicable regulatory changes and other requirements.

Background/Discussion

Contract Extension: CalOptima currently contracts with many ancillary providers to provide health care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE Members. Ancillary services include, but are not limited to, laboratory, imaging, durable medical equipment, home health, and transportation. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon Board approval.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the CalOptima Board of Directors

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. The Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS) on a phased-in basis. This transition, referred to as the Whole Child Model (WCM) program, is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016 and DHCS's All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program released on June 28, 2018, which was superseded by APL 18-023 released on December 23, 2018.

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On November 9, 2018, DHCS changed the timing of Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS has determined that more time was needed to ensure effective program preparation and ensure access to a robust number of CCS-paneled providers. Staff is requesting authority to modify the ancillary contracts to include definitions and requirements associated with the WCM program.

Additional regulatory requirements are also included in the amendments such as the new Preclusion list requirements. The Preclusion List is a CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Since many of the clinic providers contracted with CalOptima Community Network participate in CalOptima's Medicare programs, the contract is being amended to reflect this new requirement. The contracts are being updated for other regulatory updates such as no disruption in care for members who are receiving treatment for a chronic or ongoing medical condition or Long-Term Support Services upon a provider's termination.

The renewal of these contracts with existing providers will support the stability of CalOptima's contracted provider network. Contract language does not guarantee any provider volume or exclusivity and allows for CalOptima and the providers to terminate the contracts with or without cause.

This staff recommendation impacts FFS ancillary services provider contracts.

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima ancillary contracts for one year will be a budgeted item with no additional fiscal impact.

The fiscal impact of the recommended action to amend contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and reflect other requirements and regulatory changes, as applicable is unknown at this time. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. Management will include projected revenues and expenses associated with the WCM program in the CalOptima FY 2019-20 Operating Budget. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Selection of Vision Vendor and Authorize Contract for Vision Services Effective July 1, 2016

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with VSP to serve as CalOptima's Vision Vendor for Medi-Cal, OneCare Connect, OneCare and PACE members effective July 1, 2016 through June 30, 2019, with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current vision services contract for CalOptima's Medi-Cal and Medicare programs has been in place since January 1, 2007. It was awarded to VSP through a competitive procurement process. The agreement expires on June 30, 2016.

On September 3, 2015, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for vision services for the contract period commencing July 1, 2016. Following CalOptima's standard RFP process, an RFP was issued and one response was received.

Discussion
The response to the RFP was reviewed by CalOptima's evaluation team consisting of the Senior Program Manager for Medicare, Customer Service Director, Customer Service Manager, Executive Director Medical Operations, Contracting Manager, and representatives from the following departments: Finance, Compliance, and Information Services. All potential RFP responders were provided a Scope of Work document and the CalOptima base contract at the time of the RFP.

Since only one response was received, the evaluation team reviewed VSP's proposal and recommends awarding the contract to VSP.

Fiscal Impact
Under the terms of the proposed agreement, CalOptima's consolidated vision expenses are projected to decrease by 5.0% in Fiscal Year (FY) 2016-17. Management will include expenses associated with the vision services contract in the CalOptima FY 2016-17 Operating Budget.

Rationale for Recommendation
CalOptima staff believes that contracting with the recommended vision services vendor, VSP, will meet the goal of continuing to ensure that CalOptima members receive quality vision services in a cost-effective manner. CalOptima staff reviewed the vendor's response to the RFP and believes it can meet CalOptima's need for a qualified, reliable, cost effective vision vendor. Accordingly, staff recommends

that the Board authorize the CEO to contract with the existing vision vendor as a result of completion of the RFP process authorized by the Board in September, 2015.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *04/01/2016*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
VIII. G. Authorize Request for Proposal Process for Vision Service Vendor(s) Effective July 1, 2016 for Medi-Cal, OneCare, OneCare Connect, and PACE Programs

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

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to issue a Request for Proposal (RFP) for Vision Service vendor(s) and contract with the selected vendor effective July 1, 2016 through June 30, 2019, with two one-year extension options, each exercisable at CalOptima's sole discretion.

Background and Discussion
Vision services are a required benefit for Medi-Cal, OneCare Connect (OCC), OneCare (OC) and PACE members. CalOptima has been contracted with VSP since 2009 for services to OneCare and Medi-Cal members as a result of an RFP process conducted in 2008. At its January 2013 meeting, the CalOptima Board authorized the CEO to leverage the OC provider network and use it as the foundation for the Duals Delivery system. Based on this authority, the existing OC contracts were amended to also apply to OCC. The current vision services vendor contract expires on June 30, 2016, based on the previous contract extensions.

As indicated, VSP has been the sole vision provider contracted with CalOptima since 2009 as a result of an RFP released in 2008. In accordance with vendor management best practices, staff recommends completing a new RFP process which will be effective July 1, 2016.

Fiscal Impact
The recommended action is budget neutral.

Rationale for Recommendation
CalOptima staff recommends authorizing issuance of an RFP and selection of a vendor(s) effective July 1, 2016 to ensure that members continue to have access to vision services.

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 February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

12. Consider Authorizing an Amendment to Extend the Program of All-Inclusive Care for the Elderly (PACE) Contract with Mediture for Electronic Health Record Services

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Elizabeth Lee, Director, PACE Program, (714) 468-1100

Recommended Actions

Authorize CalOptima's Chief Executive Officer:

1. With the assistance of Legal Counsel, to execute an amendment to extend the current agreement for PACE electronic health record services with Mediture for three years, effective February 28, 2021, through February 29, 2024, along with two additional one-year extension options, each exercisable at CalOptima's sole discretion; and
2. To exercise one or both of the one-year extension options depending on CalOptima's business needs and vendor performance.

Background

PACE is a Medicare and Medicaid managed care service delivery model for the frail elderly that integrates acute, chronic and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima currently serves approximately 400 members via the CalOptima PACE Center located in Garden Grove and five alternative care settings located in Anaheim, Garden Grove, Huntington Beach, Santa Ana and Laguna Woods. Coordination of CalOptima PACE's complete health care services requires an electronic health record system with robust scheduling features to document the health status of participants and track center, community, and home-based clinical encounters.

Mediture was selected as the initial electronic health record vendor for CalOptima PACE in a 2016 Request for Proposal (RFP) process and was awarded a three-year contract that has been renewed twice with one-year contract extensions. Mediture is a leading provider of electronic health record (EHR) systems for PACE programs, serving 50 PACE organizations, which is 37% of all such organizations nationwide. The Mediture EHR system was developed to meet Centers for Medicare & Medicaid Services guidelines for a single plan of care, to monitor care plans, enable secure collaboration across the Interdisciplinary Team, and comply with federal and state regulatory reporting for PACE organizations. The system provides staff with electronic access to participant medical records and internal communication tools to coordinate care. As installed, the Mediture EHR is a core system of CalOptima PACE operations.

Discussion

While there are many electronic medical record systems available in the marketplace, few are tailored to meet the regulatory, clinical and operational needs of PACE programs. As noted above, Mediture has significant PACE EHR expertise, serving a substantial percentage of PACE programs. Mediture's EHR

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has met CalOptima's performance requirements and goals to date. CalOptima has developed the "PACE Without Walls" telehealth strategy and workflows based on Mediture's TruChart product. PACE Without Walls is intended to provide continuity to the PACE health care delivery system during the COVID-19 public health emergency (PHE). Prior to the PHE, the PACE model of care revolved around providing services in a facility setting. To reduce the risk of exposure for the frail, elderly members, CalOptima's PACE Without Walls allows members to receive services in their home and other community-settings. Mediture's EHR, a web-based application, is the core of how PACE clinicians and support staff provide telehealth and coordinate services to and from remote locations.

Additionally, full replacement of CalOptima PACE's current Mediture EHR solution would take more than a year to complete, including an RFP process. Renewal of the current Mediture contract rather than pursuing a new RFP process is also supported by Staff's current investment of time in implementation of PACE Without Walls and use of Mediture products as part of this telehealth strategy. The expense of this product, including workflows being utilized for PACE Without Walls, is included in the current year Board-approved operating budget. Staff anticipate elements of PACE Without Walls being incorporated into routine operations once the pandemic ends. The model provides flexibility and choice for members—to receive services in a preferred location. Now and in the post-pandemic environment, telehealth and home-based care will be considered options for the Interdisciplinary team to best meet the needs of PACE participants.

Based on these factors and a belief that the Mediture EHR system will continue to fully meet CalOptima's anticipated PACE EHR needs for the foreseeable future, Staff recommends that the Board authorize a three year extension of the current contract with Mediture, along with two one-year extension options, both exercisable at CalOptima's sole discretion.

Fiscal Impact

The CalOptima Fiscal Year 2020–21 Operating Budget approved by the Board on June 4, 2020, incorporated funding for PACE electronic health record expenses of $220,000. Staff anticipate the funding will be sufficient to cover expenses through June 30, 2021. Management will include expenses related to the recommended contract extension in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue using the current PACE electronic health record system during a time when operational stability is critical due to the ongoing pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

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Attachment to the February 4, 2021 Board of Directors Meeting – Agenda Item 12

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Mediture	7700 Equitable Drive , Suite 100	Eden Prairie	MN	55344

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

13. Consider Ratification of an Enterprise Agreement with Dell Corporation for Access to Microsoft Products

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
David O'Brien, Director, Information Services, (714) 246-1269

Recommended Action

Ratify Enterprise Agreement with Dell Corporation, a Microsoft Value Added Reseller, to continue CalOptima's access to various Microsoft software products at discounted rates.

Background

CalOptima uses many Microsoft software products and licenses to enhance productivity, collaboration, and communication, as well as provide a technology platform for core business systems. To manage these products and licenses and spread costs over their anticipated lifetimes of use, CalOptima has entered into an Enterprise Agreement (EA) with a Microsoft Value Added Reseller (VAR) that bundles the various Microsoft products together, based on the contract between the VAR and Microsoft. The EA documents are created by Microsoft to bind both the customer and VAR, and the terms are essentially non-negotiable, except as to which Microsoft products are covered and the pricing. CalOptima's previous three-year EA expired on October 31, 2020, and was renewed with a new VAR effective November 1, 2020. In addition to assisting CalOptima with bundling and managing our Microsoft software and licenses, the EA provides us a discount of no less than 2%.

Discussion

Within CalOptima's EA, there are three (3) categories:

- Software Products: CalOptima owns the physical rights to use selected software products. An example is Microsoft Visio which is used for diagraming flowchart, organizational charts, process and/or data flows.
- Enterprise Licensing: CalOptima is entitled to leverage and access enterprise systems and maintain "software assurance," which provides CalOptima with the ability to upgrade and avoid obsolescence. An example is Microsoft Windows Server, which serves as a technical platform for enterprise-level applications.
- Subscription Services: CalOptima does not own the software but can leverage products for a specified period (the term of the EA). These subscriptions are usually Cloud-based products. An example is Microsoft SharePoint Online, which is used as a platform to enhance collaboration and communication amongst staff (sharing documents and information throughout the organization).

As standard industry practice, Microsoft does not contract directly with enterprise customers, but works through a VAR that executes and manages the agreement with Microsoft. The VAR is CalOptima's partner for the term of the EA and assists with processing any orders or changes to the agreement. This is an important partnership, and CalOptima has flexibility in the choice of a VAR. CalOptima previously contracted with Crayon Software Experts as the VAR. However, for the renewal of this agreement and to

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ensure quality service, staff completed a Request for Proposal (RFP) to find the best option via a competitive bidding process that brought in three (3) bids. CalOptima staff evaluated the bids based upon overall cost, ability to effectively assist CalOptima with licensing needs, and their experience partnering with Microsoft. CalOptima staff selected and contracted with Dell Corporation as the VAR for the period of November 1, 2020 through October 31, 2023. Due to issues with the prior VAR, the renewal and RFP process were delayed, resulting in the need for Board ratification of the new EA, rather than authorization of the EA prior to execution.

Fiscal Impact
The recommended actions to ratify the continuing Microsoft EA and use Dell Corporation as the VAR are budget neutral and have no additional fiscal impact.

Rationale for Recommendation
Ratification of the Microsoft EA with Dell Corporation as the VAR, will ensure that CalOptima can fully leverage the Microsoft EA and maintain staff productivity and use of these products for the next three years at the negotiated discount rate.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Action

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Dell	One Dell Way	Round Rock	TX	78682
Microsoft	One Microsoft Way	Redmond	WA	98052
Crayon Software Experts LLC	12221 Merit Drive, Suite 800	Dallas	TX	75251

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Actions

1. Authorize expenditures for CalOptima's participation in the following community event:
    a. Up to $10,000 at the Viet Love Foundation 2021 virtual Lunar Tet Festival on February 12, 2021;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the event and expenditures.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the community outreach and education benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Beginning on March 17, 2020, state and local agencies began implementing stay-at-home orders to limit professional, social and community gatherings outside of a list of "essential activities." As a result, CalOptima staff is not currently attending any-in person community events, health and resource fairs, town halls, workshops, or other public activities while the stay-at-home orders are in effect. Additionally, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19.

CalOptima staff recognizes the unprecedented health and economic challenges our community partners and members are experiencing due to the COVID-19 and understand the importance of supporting our community partners who are serving our members during this pandemic.

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Discussion
The recommended event will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen relationships with our community partners.

a. **Viet Love Foundation virtual Lunar Tet Festival 2021.**
Staff recommends authorization of expenditures for participation in the virtual Lunar Tet Festival. This event celebrates the new lunar year and preserves the Vietnamese culture and traditions with the surrounding community. The event will provide CalOptima an opportunity to increase our visibility with our Vietnamese members and share information about CalOptima's programs and services. Vietnamese members comprise approximately thirteen percent of CalOptima's total membership. CalOptima has provided sponsorship and participated in other Lunar Tet Festival events, in non-virtual format, for seven years. This is the first year CalOptima would be sponsoring this non-profit organization, Viet Love Foundation.

Staff recommends CalOptima's continued support for this event in virtual format with a $10,000 financial commitment for 2021, which includes the following: company logo display on stage background screen through-out the event, thirty (30) mentions on stage, forty (40) radio impressions and twenty-five (25) television impressions. The event will be televised on the Vietnamese TV station and shared on social media platforms including YouTube, Facebook and Instagram.

Last year's in-person event drew over 40,000 visitors. This televised event will provide an opportunity to increase CalOptima's visibility in the Vietnamese community and may reach a larger audience given this virtual platform. Other community events have transitioned to a virtual platform during COVID-19 and have reported similar or greater attendance over prior in-person events. This is an educational event that will provide an opportunity for outreach and education in the Vietnamese community and serve members speaking one or more of CalOptima's threshold languages, providing outreach to this under-served and hard to reach population.

CalOptima staff has reviewed the request, and it meets the requirements for participation as established in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability; and
6. Available budget.

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CalOptima's involvement in community events is coordinated by the Community Relations Department. The Community Relations Department will take the lead to coordinate CalOptima's information and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item is based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact
Funding for the recommended action of up to $10,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2020-21 Operating Budget approved by the CalOptima Board of Directors on June 4, 2020.

Rationale for Recommendation
Staff recommends approval of the recommended actions in response to the COVID-19 pandemic as an opportunity to educate the community about CalOptima and the Medi-Cal program and the healthcare services CalOptima makes available in support of our community partners.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Board Action
2. Sponsorship Request from Viet Love Foundation for the virtual Lunar Tet Festival 2021

/s/ Richard Sanchez — *01/27/2021*
Authorized Signature — **Date**

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Attachment to the February 4, 2021 Board of Directors Meeting – Agenda Item 14

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Viet Love Foundation, Inc.	9315 Bolsa Ave., 166 Suite B	Westminster	CA	92683

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Viet Love Foundation
Domestic Non Profit 501(c)(3) Corporation, EIN-46-4243769, Founded 2013
Tel: 714.306.8045 9315 Bolsa Ave, #166, Westminster, CA 92683

January 20, 2021

Mr. Richard Sanchez, CEO

CalOptima

505 City Parkway West

Orange, CA 92868

Re: Sponsorship for the televised 2021 Lunar Tet Festival-Friday, February 12, 2021

Dear Mr. Sanchez:

You are appreciated for the continued support of the Lunar Tet Festival held annually. Last year, the Lunar Tet Festival had over 40,000 people in attendance and the Disney's Mickey Mouse Made a Special Appearance at the Tet Parade which was also the first time Disneyland partnered with the parade committee. The whole event was a success.

The Lunar Tet Festival is the most important celebration in Vietnamese culture. The Lunar Tet Festival celebrates the arrival of spring based on the Vietnamese calendar, which is usually done yearly within January and February. Vietnamese people celebrate the Lunar New Year annually, which is based on a lunisolar calendar (calculating both the motions of Earth around the Sun and of the Moon around Earth.

It is believed that Tet is a time for spiritual rejuvenation and this allows families to come together and pay tribute to their ancestors while celebrating the arrival of the New Year. The cultural, spiritual, and traditional importance of this celebration is vital to many of the communities throughout Orange County.

This year, due to the resurgence of COVID-19, which is ravaging the world, we will be hosting the Lunar Tet Festival virtually. The Lunar Tet Festival content will be live on TV and some other medium such as YouTube, Facebook, and Instagram on Friday, February 12, 2021. Families will be able to celebrate this traditional holiday from home.

We would like to ask CalOptima's sponsorship of $10,000 for the 2021 Lunar Tet Festival which will be held virtually. Your contribution can definitely make a difference and we are looking forward to building a successful partnership with your company.

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LUNAR NEW YEAR FESTIVAL 2021 SPONSORSHIP PACKAKE

Feb 12th, 2021, Pre-recorded event at PREMIERE STUDIO, Fountain Valley, Ca

It will be on social media and Vietnamese Television at 7pm

SPONSORSHIP PACKAGES

DIAMOND SPONSOR $10,000

Company logo display on Stage's background screen through-out the event

Thirty (30) mentions on stage

Forty (40) radio impressions

Twenty-five (25) Television impressions

GOLD SPONSOR $7,000

Company logo display on Stage's background screen Fifteen (15) times

Twenty (20) mentions on stage

Twenty-five (25) radio impressions

Fifteen (15) television impressions

SILVER SPONSOR $3,500

Company logo display on Stage's background screen Five (5) times

Ten (10) mentions on stage

Fifteen (15) radio impressions

BRONZE SPONSOR $1,000

Company logo display on Stage's background screen Moon Festival (1 time)

Five (5) mentions on stage

Sincerely

RobertPham

Robert Pham, President

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

15. Consider Authorizing an Amended and Restated Health Network Contract for Kaiser Foundation Health Plan Inc. and Amendments Incorporating Operational Provisions and Revised Capitation Rates

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute:

1. An Amended and Restated Medi-Cal Health Network Contract with Kaiser Foundation Health Plan, Inc., incorporating language changes, effective July 1, 2019 through June 30, 2021; and
2. Amendments incorporating all changes made in the Health Network contracts since July 1, 2019, including certain operational requirements and revisions to the capitation rates

Background

Kaiser Foundation Health Plan Inc. (Kaiser) participates in CalOptima's Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization (HMO) Health Network model. CalOptima's health network contracts are renewed on an annual basis each July, subject to Board approval. On June 6, 2019, the CalOptima Board authorized an Amended and Restated Contract with all Health Networks. The Board has approved five (5) Amendments to the Amended and Restated Health Network Contract since that time.

Kaiser did not, however, execute the Amended and Restated Contract or the five (5) subsequent Amendments and, instead, engaged CalOptima staff in a series of discussions regarding certain contract terms. The Board authorized extensions of the existing contract on August 6, 2020, October 1, 2020, November 5, 2020, and December 3, 2020, to accommodate continued contract discussions. The most recent extension is effective through February 4, 2021.

Discussion

Kaiser and CalOptima staff have had extensive discussions and have come to an agreement regarding the terms of the Amended and Restated Contract. The document has been revised and some terms updated to address legacy language and operational requirements addressing Kaiser's business model. Board authorization to execute the Amended and Restated Contract effective July 1, 2019 through June 30, 2021 is now requested. Authorization is also sought to execute Amendments I through V, which include but are not limited to:

- Operational requirements including extending funding for the Health Homes Program
- Extension of Behavioral Health Treatment and Hepatitis C supplemental capitation payments
- Revised capitation rates reflecting a reduction for Medi-Cal Expansion members
- Removal of pharmacy risk and capitation upon implementation of the carve-out of the pharmacy benefit by the State

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The revised capitation rates for Medi-Cal Expansion members will be effective February 1, 2021, and the Amended and Restated Contract will be in effect through June 30, 2021, consistent with CalOptima's contracts with the other Health Network.

Fiscal Impact

The recommended actions to retroactively enter into the Board-approved Amended and Restated HMO Health Network Contract with Kaiser effective July 1, 2019, through June 30, 2021, and amendments incorporating operational provisions and revised capitation rates are budgeted items. Funding for the contract and related amendments has been included in the Board-approved Fiscal Year (FY) 2019-20 and FY 2020-21 Operating Budgets.

Rationale for Recommendation

Authorization to execute the Amended and Restated Medi-Cal Health Network Contract and update capitation rates will ensure that Kaiser is operating under the current contractual terms and conditions as required by CalOptima's regulators and operational requirements, and will implement the rebased capitation rates.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated November 5, 2020; "Consider Authorization of a Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term," which includes the following attachments:
   - Previous Board Action dated October 1, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term"
   - Previous Board Action dated August 6, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment"
3. Previous Board Action dated June 4, 2020; "Consider Authorizing Extension and Amendments of the CalOptima Medi-Cal Full-Risk HMO, Shared-risk, and Physician-Hospital Consortium Health Network Contracts"
4. Previous Board Action dated April 2, 2020; "Consider Actions Related to Coronavirus (COVID-19) Pandemic"
5. Previous Board Action dated March 5, 2020; "Consider Ratification of Amendments to the Medi-Cal Health Network Contracts, Except AltaMed Health Services Corporation, and Expenditures for Whole-Child Model Program Implementation"
6. Previous Board Action dated October 3, 2019; "Consider Authorizing Amendments to Medi-Cal Health Network Contracts Except Those Associated with AltaMed Health Services Corporation to Include Language for the Health Homes Program and Consider Ratifying Memorandum of Understanding with HCA Related to the Health Homes Program"

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7. Previous Board Action dated September 5, 2019; "Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transportation (GEMT)"
8. Previous Board Action dated June 27, 2019; "Consider Ratification of Amendments to Medi-Cal Health Network Contracts, Excluding Those Involving the CHOC Physicians Network"
9. Previous Board Action dated June 6, 2019; "Consider Authorizing Amended and Restated Medi-Cal Health Network Contract for Kaiser Foundation Health Plan, Inc to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates"

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Action

Authorize amendment to the current Kaiser Foundation Health Plan, Inc. Health Network Contract to extend the current term through the date of the next CalOptima Board meeting, December 3, 2020.

Background

Kaiser Foundation Health Plan, Inc. (Kaiser) participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Kaiser's current Health Network Contract expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS-required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments.

CalOptima and Kaiser staff worked with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. To allow time for Kaiser and CalOptima to obtain all necessary information and final clarification from DHCS and complete discussions regarding the Amended and Restated Contract, the parties entered into an initial ninety (90) day extension of Kaiser's current contract through September 30, 2020. Due to the June 30, 2020 expiration date of the current Kaiser Health Network Contract, this extension was ratified by the Board on August 6, 2020. As of the last Board of Directors' Meeting, on October 1, 2020, it was determined that review of certain provisions in the Amended and Restated contract was still in progress. As such, an additional month-long extension was requested until November 5, 2020.

Discussion

The parties continue to review certain provisions of the Amended and Restated Contract that memorialize operational requirements in light of Kaiser's unique model as well as the five (5) subsequent amendments that implement Proposition 56, Health Homes Program requirements and other terms (Contract Amendments). Additionally, because Kaiser is the only CalOptima Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser staff are addressing terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract when the State implements its Medi-Cal Rx program effective January 1, 2021 including, revised rates and DHCS-mandated transition terms.

While CalOptima and Kaiser staff have attempted to complete all contract and amendment revisions by November 5, 2020, additional time is required to fully explore whether the parties will be able to resolve and finalize the remaining issues. Staff has requested an additional month-long extension of the current

Kaiser Contract on the same terms and conditions to complete the discussions and finalize the Amended and Restated Contract and Contract Amendments. Because Staff intends to present the final Kaiser Amended and Restated Contract and Contract Amendments to the Board for approval at the December 3, 2020 meeting, Staff requests that the Board approve extension of the current Kaiser Health Network Contract through that date.

Fiscal Impact

The recommended action to authorize extension of the current Kaiser Health Network Contract to through December 3, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

Amending the current Kaiser Health Network Contract to extend through December 3, 2020, the date of the Board's next meeting, under the same terms and conditions will allow the additional time needed to review and finalize Kaiser's FY 2020-21 Amended and Restated Health Network Contract.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 6, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract"
3. Previous Board Action dated October 1, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term.

/s/ Richard Sanchez — *10/28/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
8. Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment

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

Recommended Actions
Ratify the amendment to the Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network contract, extending the term through September 30, 2020.

Background/Discussion
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Each of CalOptima's contracts with its 12 twelve Medi-Cal Health Networks, including Kaiser, include a provision permitting an annual one-year extension of the contract subject to CalOptima Board of Directors' approval and signed contract amendments. Kaiser's current Health Network Contract ("Kaiser Contract") expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments. Kaiser has not, however, executed the Amended and Restated Contract. CalOptima and Kaiser have been working with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. The parties have also been reviewing certain contract provisions that memorialize operational requirements in light of Kaiser's unique staff model.

In order to allow time for Kaiser and CalOptima to obtain final clarification from DHCS and finalize discussions with Kaiser, the parties entered into a ninety (90) day extension of the Kaiser Contract through September 30, 2020, subject to Board approval. Additionally, because Kaiser is the only Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser also need to address contract terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract. The pharmacy benefit carve-out will be effective January 1, 2021 for all Managed Care Plans, including CalOptima.

Staff recommends ratification of the Kaiser Contract amendment to provide additional time to obtain DHCS's final guidance, and for the parties to reach agreement on the Amended and Restated Contract terms.

Fiscal Impact
The recommended action to ratify the amendment to the Kaiser Contract to extend the term through September 30, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020.

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Rationale for Recommendation

This extension will allow additional time to review and finalize Kaiser's FY 2020-21 Health Network contract.

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Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action Dated June 4, 2020; "Authorize Extension and Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts with Kaiser Permanente

/s/ Richard Sanchez *07/29/2020*

Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing Extension and Amendments of the CalOptima Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network HMO, Shared-Risk, and Physician-Hospital Consortium Health Network contracts to:

1. Extend the term through June 30, 2021;
2. Reflect adjustments in Health Network's capitation rates and add language reflecting that Directed Payments will be made pursuant to CalOptima Policy and Procedures effective July 1, 2020; and
3. Revise the Shared Risk program attachment in the Shared Risk group contracts to align with changes made to Policy FF.1010 related to the description of the Shared Risk budget.

Background/Discussion

CalOptima currently contracts with 12 health networks to provide care to CalOptima Medi-Cal members. The continued renewal of the contracts will support the stability of CalOptima's contracted provider network. CalOptima's current Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts listed below will expire on June 30, 2020:

Full Risk HMO:
Heritage Provider Network, Inc.
Kaiser Foundation Health Plan, Inc.
Monarch Health Plan, Inc.
Prospect Health Plan, Inc.

Shared Risk:
AltaMed Health Services Corporation
ARTA Western California, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates Inc. of Mid Orange County
Talbert Medical Group, P.C.
United Care Medical Group, Inc.

Physician-Hospital Consortium:
CHOC Physician's Network and Children's Hospital of Orange County
AMVI Care Health Network and Fountain Valley Regional Hospital and Medical Center
Family Choice Medical Group, Inc. and Fountain Valley Regional Hospital and Medical Center

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Staff recommends extending the above Health Network contracts for one year, through June 30, 2021. Extension of the Heath Network contracts is essential to ensuring that members assigned to health networks have access to covered healthcare services.

Health Network Capitation Rate Adjustment

Medi-Cal Classic Rebasing: For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Classic capitation rates effective July 1, 2020, following CalOptima's periodic rebasing process. Rebasing ensures capitation rates paid to our Health Network providers include appropriate reimbursement for medical and non-medical expenses.

Medi-Cal Expansion (MCE) Rates: In 2014, Medi-Cal eligibility was expanded to cover single, low-income individuals ages 19-64, known as Medi-Cal Expansion (MCE). The Department of Health Care Services (DHCS) provided additional funding to support newly eligible MCE members, a group separate from the Medi-Cal Classic member population. Due to the absence of any utilization information at the program's inception, capitation rates for MCE members were set based on assumed population risk from the beginning of the expansion to date.

For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Expansion (MCE) capitation rates effective July 1, 2020. DHCS has applied multiple downward adjustments to CalOptima's MCE capitation rates due to a lower average acuity than first anticipated. As such, staff continues to analyze the appropriateness of MCE capitation rates paid to Health Networks. Based on an actuarial analysis of utilization data, additional reductions to MCE capitation rates are appropriate.

Over the course of the program, sufficient time has passed to compile reliable Chronic Disability Payment System (CDPS) diagnostic information necessary for risk adjustment. With the CDPS information now available to make determinations regarding acuity, staff proposes to amend the current Health Network contracts to adjust the MCE rate, either up or down, based on CDPS data. With margins being reduced, it is more important to implement risk adjustment to ensure capitation payments are commensurate with population acuity. Staff has provided notices to the Health Networks that their MCE capitation rate will be risk adjusted starting July 1, 2020.

OB Kick Payment Rate Increase: Per Policy FF.1005f, CalOptima has historically provided all Health Networks a supplemental payment for qualifying covered obstetric delivery services. The current rates, set in 2010 when the Maternity Kick Payment program began, are $793 for professional services and $4,451 for facility fees. For the new contract term, staff recommends authorization to increase these rates to $900 for professional services and $5,000 for facility fees for all Health Networks, with the exception of Kaiser Health Plan, Inc. which is being reimbursed according to the terms set forth in a March 7, 2019 Board Action.

Directed Payments

Periodically CalOptima is required through DHCS or CMS guidance to make statutorily mandated retrospective payments to its Health Networks. These payments are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF) supplemental payments. In many cases these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years retrospectively, and often based on actual claims paid. Until now, CalOptima has made these DHCS- and CMS- defined supplemental payments to its health networks via contract amendment, as notification came down from the state or federal government. Given the ongoing nature of these payments – including those given under Proposition 56 - multiple amendments, retroactive contract terms, and subsequent timeliness concerns for payment to the impacted providers have been ongoing concerns. To mitigate this, staff recommends that moving forward, Directed Payments be administered according Policy & Procedure FF. 2011 ("Directed Payments"), which addresses Directed Payment programs listed below. Directed Payment is an add-on payment or minimum fee payment required by DHCS to be made to eligible providers for qualifying services (identified below) with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments. As an alternative to requesting authority to amend these contracts on each individual occasion, Policy FF.2011 directs CalOptima to reimburse Health Networks for Direct Payments as they are mandated, pursuant to qualifying services being rendered, providing both policy and procedure guidelines.

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance
Physician Services	7/1/2017 to 12/31/2020	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
Ground Emergency Medical Transport (GEMT)*	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 APL 20-002 released January 31, 2020

**Directed Payments for GEMT Services are not applicable to Shared-Risk Group*

Staff anticipates that Policy FF.2011 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Shared Risk Pool Revisions
Pursuant to a separate Board action, Staff has revised CalOptima Policy FF.1010: Shared Risk Pool to clarify language regarding the Shared Risk pool budget in relation to Coordination of Benefits (COB) recoveries. This revision clarifies that:

1) COB recoveries reduce expense but do not increase revenue; and

2) Since CalOptima is self-insured, reinsurance premium will no longer be allocated to the risk pool.

Fiscal Impact
The recommended actions to enter into amended Medi-Cal Health Network contracts to extend through June 30, 2021, add language reflecting changes to how the Directed Payments are handled, and align Shared Risk group contracts with revisions to CalOptima Policy FF.1010 are not expected to have a fiscal impact.

Costs associated with the recommended action to adjust capitation rates for these contracts, with the exception of Kaiser Foundation Health Plan, Inc., have been included in the proposed CalOptima Fiscal Year (FY) 2020-21 Operating Budget pending Board approval. These proposed changes represent an approximately 2.0% overall reduction in Medi-Cal Classic health network capitation payments, projected at an estimated $8 million in FY 2020-21. In addition, the budget proposes an overall reduction of 7% to the MCE Professional capitation rate and a reduction of 14% to the MCE Hospital capitation rate. Aggregate decreases to MCE Professional capitation expenses and associated shared risk pools are projected to be $50 million in FY 2020-21.

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Action
2. Previous Board Action dated June 6, 2019, Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates
3. Previous Board Action dated December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole Child Model Implementation Date
4. Previous Board Action dated April 2, 2020, Consider Approval of CalOptima Medi-Cal Directed Payments Policy

5. Policy & Procedure FF.2011: Directed Payments
6. Policy & Procedure FF.1005f: Special Payments: Supplemental OB Delivery Care Payment
7. Previous Board Action dated March 7, 2013, Authorize and Direct Chief Executive Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan, (Kaiser)

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into Amended and Restated Full Risk Health Network Contracts with Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. effective July 1, 2019 date that address the following:

a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board in a separate Board action;

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to:

emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

The budget for Fiscal Year (FY) 2019-20 reflects a decrease in Medi-Cal Expansion (MCE) revenue and an increase in Medi-Cal classic. Capitation reimbursement levels paid by CalOptima to providers for the MCE population is higher than levels that are supported by cost and utilization data. This fact coupled with the reduction in revenue from DHCS has resulted in decreases to the MCE capitation rates for the Health Networks. For the Medi-Cal Classic population Staff recommends an increase to both Professional and Hospital capitation for Adult TANF and SPD members. The amended and restated contract reflects revised capitation rates effective July 1, 2019 to the extent authorized by the Board in a separate Board action.

Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

Costs associated with the recommended action to revise capitation rates for these contracts have been included in the proposed CalOptima FY 2019-20 Operating Budget pending Board approval. The budget includes proposed increases of 4% to the Adult Temporary Assistance for Needy Families (TANF) and seniors and persons with disabilities (SPD) Professional capitation rates and 6% to the Adult TANF and SPD Hospital capitation rates. The increases total approximately $7.5 million in FY 2019-20.

In addition, the budget proposes a reduction of 8% to the MCE Professional capitation rate and a reduction of 21% to the MCE Hospital capitation rate. Aggregate decreases to MCE capitation expenses and associated shared risk pools are projected to be $95 million in FY 2019-20.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

/s/ Michael Schrader — *5/29/2019*

Authorized Signature — **Date**

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
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Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

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[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

c. Current CalOptima members age of 21 and over who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

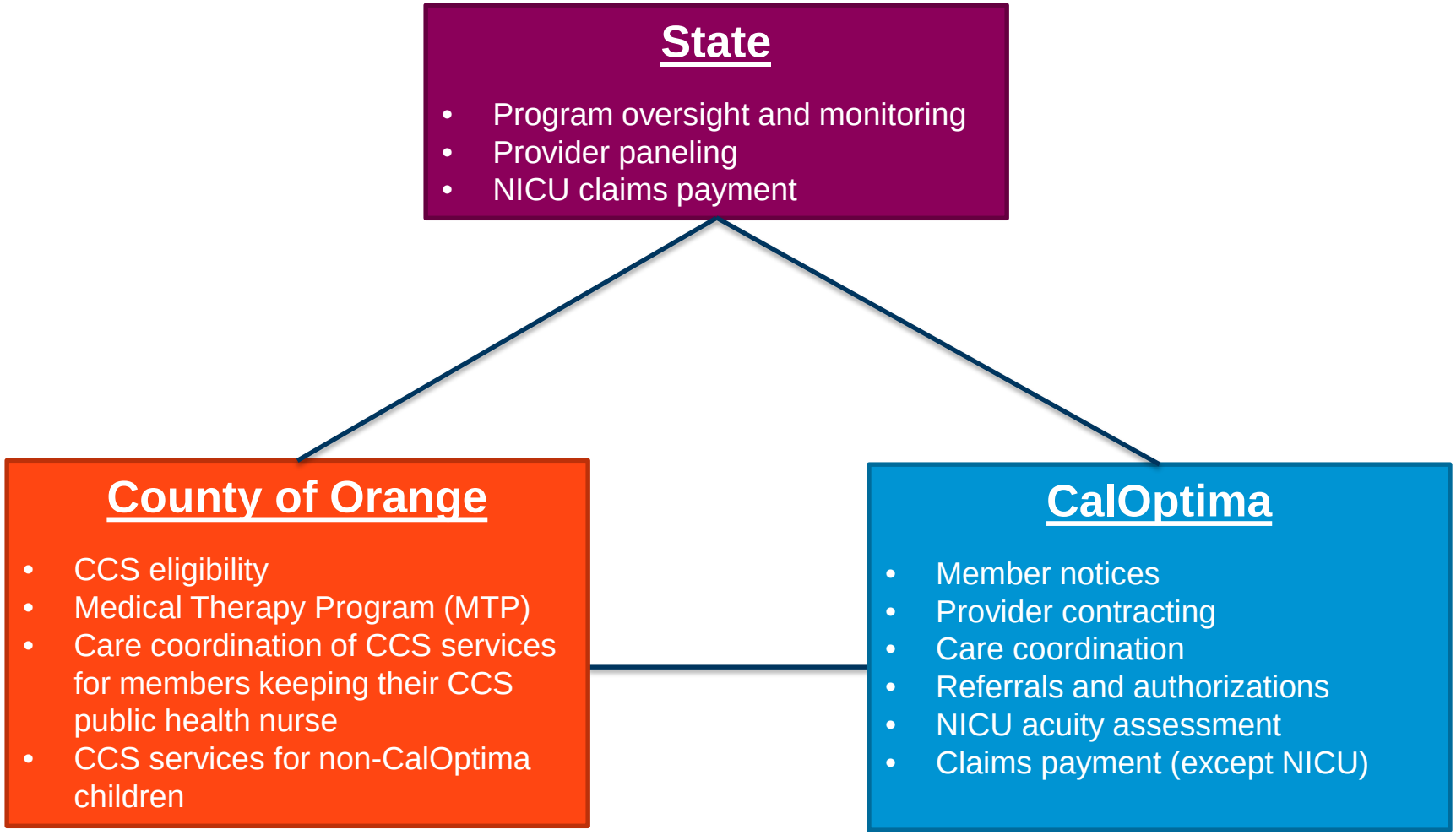
Back to Agenda Back to Item

Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

CalOptima
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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

c. Current CalOptima members age of 21 and over who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

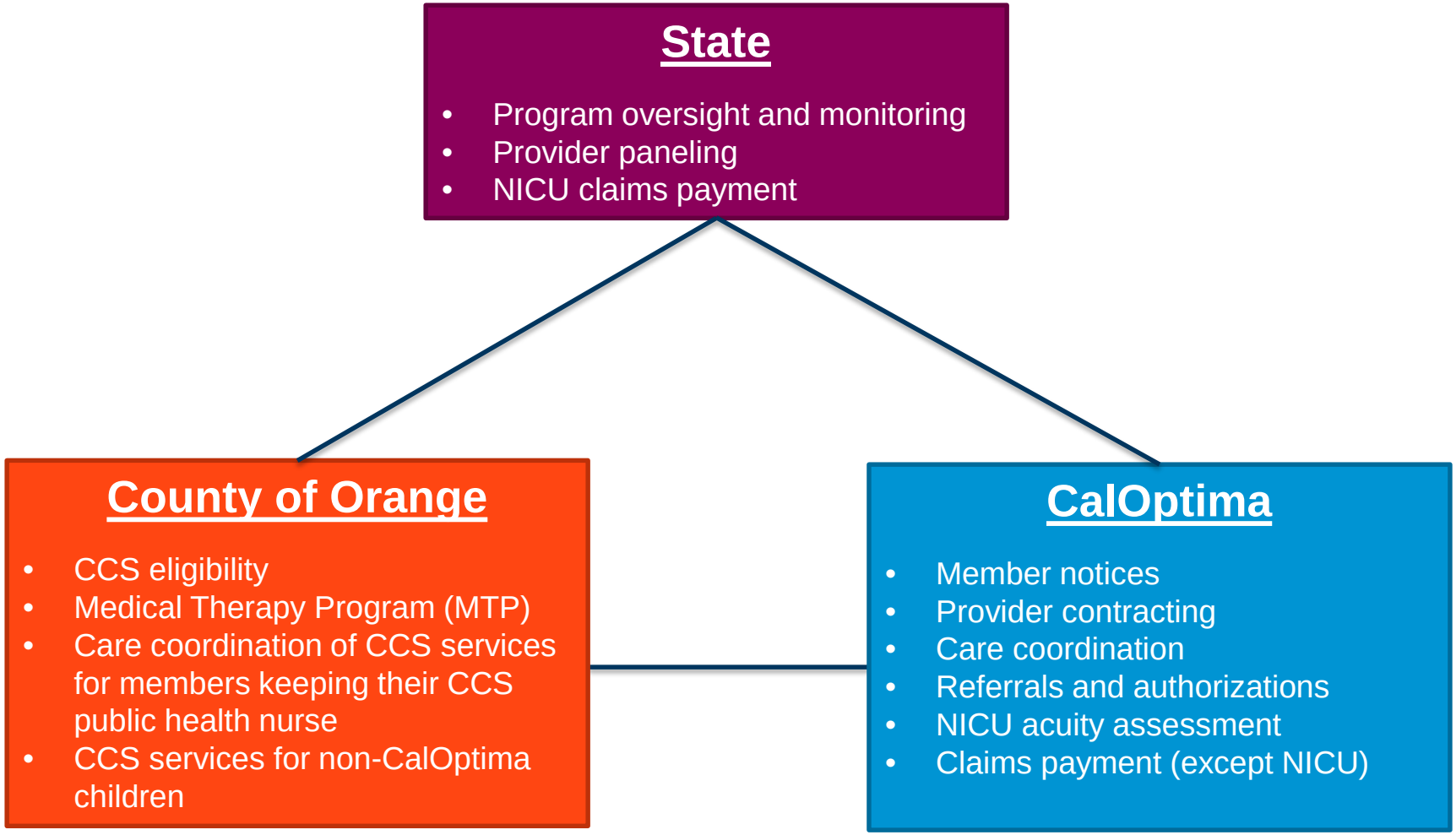
Back to Agenda Back to Item

Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

CalOptima
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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

Back to Agenda Back to Item

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

Contact

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

Recommended Actions

That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.

4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

Background/Discussion

DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

Fiscal Impact
The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

Policy:	FF.2011
Title:	Directed Payments
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

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7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any

administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday;

         2) After the first birthday and before or on the second birthday; or

3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

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

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

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

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M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[1]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[1]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[2]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[2]*Payment obligations for rates of at least $29 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[3]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[3]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[4]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[4]Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

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

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

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

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

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

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

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

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

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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.

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

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

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

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Server:files.medi-cal.ca.gov |File:/pubsdoco/newsroom/newsroom_27057.asp |Last Modified:9/21/2018 5:14:04 PM

Policy:	FF.2011
Title:	**Directed Payments**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	*/s/ Richard Sanchez 04/15/2020*
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

Back to Agenda Back to Item

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

    a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

    b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

    a. The following Developmental Screening Services are eligible for an Add-On Payment:

        i. A routine screening when provided:

            1) On or before the first birthday;

            2) After the first birthday and before or on the second birthday; or

            3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health

Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

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

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

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/10/2020	Department of Health Care Services (DHCS) [file and use]

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Policy:	FF.1005f
Title:	**Special Payments: Supplemental OB Delivery Care Payment**
Department:	Finance
Section:	Not Applicable
CEO Approval:	/s/ *Michael Schrader 08/08/2019*
Effective Date:	01/01/2010
Revised Date:	07/01/2019

I. PURPOSE

This policy defines the criteria for a **Health Network***, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), to receive a supplemental obstetrical (OB) delivery care payment for qualifying **Covered Services** provided to a **Member** enrolled in Medi-Cal for dates of service on and after January 1, 2010, in accordance with this policy.

II. POLICY

A. Effective for dates of service on and after January 1, 2010, CalOptima shall make a supplemental payment for qualifying **Covered Services** that include OB delivery care at a rate set forth in the **Contract for Health Care Services**, in accordance with the terms and conditions of this Policy.

B. A **Health Network** shall qualify for the supplemental payment for **Covered Services** that include OB delivery care if:

1. On the date of delivery, the **Member** was eligible with CalOptima for less than six (6) consecutive months;

2. On the date of delivery, the **Member** was between fifteen (15) and forty-four (44) years of age;

3. For the physician supplemental OB delivery care payment, **Covered Services** include physician services for normal and C-section delivery and assistant surgeon services billed with any of the following Current Procedural Terminology (CPT) codes: 59400, 59409, 59510, 59514, 59610, 59612, 59618, 59620; and modifier codes AG, or 80, as applicable;

4. For the hospital supplemental OB delivery care payment, **Covered Services** include hospital inpatient services related to an obstetric stay billed with the following Revenue Codes: 720, 721, 722, or 729;

5. The **Health Network** reimbursed the **Provider** for the **Covered Service**;

6. The **Health Network** authorized such services; and

7. The **Health Network** submits **Encounter** data in accordance with Section III.A of this policy.

C. If a **Health Network** identifies an **Overpayment** of a supplemental OB delivery care payment, the **Health Network** shall return the **Overpayment** within sixty (60) calendar days after the date on which the **Overpayment** was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the **Overpayment**. CalOptima shall coordinate with the **Health Network** on the process to return the **Overpayment**.

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

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III. PROCEDURE

A. **Encounter** Data Submission

1. A **Health Network** shall report an **Encounter** in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such **Encounter**.

2. CalOptima shall qualify **Health Network Encounter** Data for valid CPT and Revenue codes, and report the valid **Encounters** for payment authorization.

B. A **Health Network** shall instruct a **Provider** to utilize the appropriate CPT and Revenue codes to bill for **Covered Services** provided to a **Member**.

C. Processing of Physician Claims

1. A **Health Network** shall process an eligible claim submitted by a **Provider** for physician services at a rate set forth in their contractual agreement.

2. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

D. Processing of Hospital Claims

1. **Physician Hospital Consortium (PHC)** or **Health Maintenance Organization (HMO)**

a. A **PHC** or **HMO** shall process an eligible claim submitted by a **Provider** for hospital inpatient services related to an obstetrical stay at a rate set forth in their contractual agreement.

b. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

2. Shared Risk Group (SRG)

a. CalOptima shall process a claim for hospital inpatient services related to an obstetrical stay provided to a **Member** enrolled in an **SRG** in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a **Shared Risk Group.**

b. CalOptima shall make a supplemental payment funding adjustment to the Shared Risk Pool in accordance with Section III.E.1 of this Policy.

E. Hospital Supplemental OB Delivery Care Payment

1. **SRG**: CalOptima shall make a supplemental payment funding adjustment to a Shared Risk Pool at a rate set forth in the **Contract for Health Care Services** for a covered hospital inpatient obstetrical delivery based on actual claims paid in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

2. **PHC** or **HMO**: CalOptima shall make a supplemental payment at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

F. Physician Supplemental OB Delivery Care Payment

1. CalOptima shall make a supplemental payment to a **Health Network** for physician services for normal and C-section delivery and assistant surgeon services at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

G. With the exception of payment funding adjustment to a Shared Risk Pool described in Section III.E.1 of this Policy, CalOptima shall:

1. Distribute physician supplemental payments one (1) time each quarter; and

2. Provide a Remittance Advice Detail (RAD) to the **Health Network** for each quarterly payment that includes the following information:

a. **Provider** name;

b. **Provider** identification number;

c. **Member** name;

d. **Member** identification number;

e. Date of service;

f. Bill code; and

g. Amount paid.

H. A **Health Network** has the right to file a complaint disputing CalOptima's supplemental OB delivery care payment in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
C. CalOptima Policy FF.1010: Shared Risk Pool
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Title 42, Code of Federal Regulations (CFR), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	01/01/2014	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2015	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2016	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	04/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2018	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2019	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. C. Authorize and Direct the Chief Executive Officer to Execute Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan (Kaiser)

Contact

Julie Bomgren, Director, Government Affairs, (714) 246-8400

Recommended Actions

1. Authorize and Direct the Chief Executive Officer (CEO) to execute a three-way agreement with the DHCS and Kaiser related to the transition of Healthy Families Program (HFP) children and Medi-Cal beneficiaries who are former Kaiser members or family-linked within the previous 12 months.
2. Authorize and Direct the CEO to execute an agreement with Kaiser related to transitioning certain defined categories of members to Kaiser as described in the two-way agreement.
3. Authorize and direct the CEO to enter into an amendment of the current Medi-Cal agreement with Kaiser consistent with these agreements.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In 1995, CalOptima entered into an agreement with Kaiser to provide health care services under CalOptima's Medi-Cal program. As a Health Network for Medi-Cal, Kaiser currently provides health care services, including pharmacy services to approximately 11,500 CalOptima Medi-Cal members. Along with CalOptima, Kaiser is a health plan in the HFP and serves approximately 13,500 HFP children in Orange County. With the elimination of HFP, and in accordance with the HFP transition implementation plan, children enrolled in Kaiser HFP will transition to CalOptima in Phase 2, anticipated to occur no sooner than April 1, 2013.

Discussion

In June 2012, the Legislature passed Assembly Bill (AB) 1494 which provides for the transition of all HFP subscribers to Medi-Cal.

In June 2012, Kaiser approached the State to consider the development of an agreement whereby Kaiser will retain its HFP members upon their transition into Medi-Cal through a direct contractual relationship with DHCS. As a direct contractual relationship in the existing managed care county delivery systems throughout California is not possible due to state and federal statutes, DHCS, Kaiser and the Medi-Cal managed care plans developed two agreements to address the HFP transition and future Medi-Cal enrollment.

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DHCS/Kaiser/Plan Agreement

The first agreement is, by its own terms, a nonbinding agreement, between DHCS, Kaiser and the managed care plans. This template has already been signed by DHCS and Kaiser. It indicates that it sets forth a framework for a seamless transition of care for current Kaiser members in the HFP and Medi-Cal beneficiaries who were Kaiser members or family-linked within the previous twelve months.

The three-way agreement includes the following provisions:

1. DHCS, Kaiser and managed care plans will work to develop a contract template for the subcontract between plans and Kaiser.
2. A centralized oversight and compliance process to include a uniform policies and procedures audit program will be created to oversee Kaiser's obligations under the contract template (it may be necessary for two processes, one for Northern California and one for Southern California). The agreement indicates that this process will be conducted and funded by DHCS unless otherwise agreed to by the parties.
3. A process will be developed to improve the existing and future enrollment processes for Kaiser members including a validation process (of the applicant's eligibility to choose Kaiser).
4. In COHS counties including Orange County, the enrollment process for current/previous Kaiser members will mimic the existing process for all Medi-Cal members. The COHS plans such as CalOptima will assign to Kaiser new Medi-Cal members currently or previously enrolled with Kaiser in the previous twelve months or family-linked in the previous twelve months. This auto assignment to Kaiser is contingent upon COHS plans receiving required and accurate data from Kaiser and federal and state regulators. COHS members will be assigned to Kaiser only upon verification of previous coverage by Kaiser.
5. The agreement does not restrict the ability of Medi-Cal beneficiaries to choose a different provider than Kaiser during or after the beneficiary has been assigned to CalOptima.

Kaiser/Plan Agreement

The second agreement, between Kaiser and the managed care plan, is titled "Care Continuity Agreement" and defines the beneficiaries for whom the managed care plan will ensure transition to Kaiser as: 1) all members of CalOptima currently assigned to Kaiser; 2) individuals who are eligible for Medi-Cal on and after January 1, 2014 under Medi-Cal expansion and who enroll in CalOptima and are assigned to Kaiser; 3) HFP beneficiaries who are Kaiser members on the effective date of the transition; and 4) beneficiaries who are eligible for Medi-Cal or HFP after the effective date of the transition and who were Kaiser members or family-linked within the previous twelve months. This agreement has been signed by Kaiser but does not include aid codes on the attachments.

The two-way agreement includes the following provisions:

1. Kaiser will provide rate development template (RDT) data to managed care plans for inclusion in the plan RDT for the rate setting process.

2. Effective July 1, 2013, for aid codes not directly funded through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), an administrative withhold by the managed care plan will not exceed 2% of the net capitation Medi-Cal amount (the withhold may be based on the plan risk-adjusted equivalent of the net capitation amount). For aid codes directly funded through CHIPRA, there will be no administrative fee withhold.
3. Managed care plan contracts with Kaiser will be amended to include these provisions. However this Agreement indicates that it may be terminated only upon execution of an amendment to the parties, and that the terms of this Agreement will be re-evaluated in five years.
4. Kaiser may enter into a direct contract with DHCS if Kaiser is unable to reach a subcontracting agreement with Plan.

Upon approval by the Board of Directors, CalOptima modified its Medi-Cal auto assignment policy to accommodate the transition of HFP members and to the extent possible, preserve the provider/member and member/health network relationships. For children transitioning from other HFP health plans to Medi-Cal, CalOptima anticipates that DHCS will provide the Medi-Cal health plan a file that will include the incoming health plan code and name for transitioning HFP children. In order to ensure a seamless transition of care for Kaiser members, it will be necessary that CalOptima receive a timely, clean file for processing. Otherwise, CalOptima staff will follow our standard new member auto assignment process.

Fiscal Impact
With Kaiser's current membership, the 2% administrative withhold provision equates to approximately $250,000 annually which is one-half of the amount regularly included in DHCS capitation rates for administration. However, as an HMO, Kaiser will perform some of the functions that CalOptima would normally be responsible for, which will reduce CalOptima's cost accordingly.

Rationale for Recommendation
These template agreements were negotiated with DHCS, Kaiser and managed care plans and the provisions for transitioning HFP members are consistent with the requirements included in the recent amendment to CalOptima's Primary Agreement with DHCS related to the transition of HFP subscribers into Medi-Cal.

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

Attachments
None

/s/ Michael Schrader — *3/1/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

Recommended Action
Ratify the amendment to the current Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network Contract to extend the current term through the date of the next CalOptima Board meeting, November 5, 2020.

Background
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Kaiser's current Health Network Contract expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS-required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments.

CalOptima and Kaiser staff worked with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. To allow time for Kaiser and CalOptima to obtain all necessary information and final clarification from DHCS and complete discussions regarding the Amended and Restated Contract, the parties entered into an initial ninety (90) day extension of Kaiser's current contract through September 30, 2020. Due to the June 30, 2020 expiration date of the current Kaiser Health Network Contract, this extension was ratified by the Board on August 6, 2020.

Discussion
The parties continue to review certain provisions of the Amended and Restated Contract that memorialize operational requirements in light of Kaiser's unique model as well as the five (5) subsequent amendments that implement Prop 56, Health Homes Program requirements and other terms (Contract Amendments). Additionally, because Kaiser is the only CalOptima Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser staff are addressing terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract when the State implements its Medi-Cal Rx program effective January 1, 2021 including, revised rates and DHCS-mandated transition terms.

While CalOptima and Kaiser staff have attempted to complete all contract and amendment revisions by September 30, 2020, it will take another thirty (30) days to finalize these issues. Kaiser has requested an additional thirty (30) day extension of the current Kaiser Contract on the same terms and conditions to complete the discussions and finalize the Amended and Restated Contract and Contract Amendments. Because Staff intends to present the final Kaiser Amended and Restated Contract and Contract

Amendments to the Board for approval at the November 5, 2020 meeting, Staff requests that the Board ratify the extension of the current Kaiser Health Network Contract through that date.

Fiscal Impact

The recommended action to amend the current Kaiser Health Network Contract to extend the term through November 5, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

Amending the current Kaiser Health Network Contract to extend through November 5, 2020, the date of the Board's next meeting, under the same terms and conditions will allow the additional time needed to review and finalize Kaiser's FY 2020-21 Amended and Restated Health Network Contract.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 6, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract"

/s/ Richard Sanchez — *09/23/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
8. Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment

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

Recommended Actions
Ratify the amendment to the Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network contract, extending the term through September 30, 2020.

Background/Discussion
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Each of CalOptima's contracts with its 12 twelve Medi-Cal Health Networks, including Kaiser, include a provision permitting an annual one-year extension of the contract subject to CalOptima Board of Directors' approval and signed contract amendments. Kaiser's current Health Network Contract ("Kaiser Contract") expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments. Kaiser has not, however, executed the Amended and Restated Contract. CalOptima and Kaiser have been working with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. The parties have also been reviewing certain contract provisions that memorialize operational requirements in light of Kaiser's unique staff model.

In order to allow time for Kaiser and CalOptima to obtain final clarification from DHCS and finalize discussions with Kaiser, the parties entered into a ninety (90) day extension of the Kaiser Contract through September 30, 2020, subject to Board approval. Additionally, because Kaiser is the only Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser also need to address contract terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract. The pharmacy benefit carve-out will be effective January 1, 2021 for all Managed Care Plans, including CalOptima.

Staff recommends ratification of the Kaiser Contract amendment to provide additional time to obtain DHCS's final guidance, and for the parties to reach agreement on the Amended and Restated Contract terms.

Fiscal Impact
The recommended action to ratify the amendment to the Kaiser Contract to extend the term through September 30, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020.

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Rationale for Recommendation

This extension will allow additional time to review and finalize Kaiser's FY 2020-21 Health Network contract.

.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action Dated June 4, 2020; "Authorize Extension and Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts with Kaiser Permanente

/s/ Richard Sanchez *07/29/2020*

Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing Extension and Amendments of the CalOptima Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network HMO, Shared-Risk, and Physician-Hospital Consortium Health Network contracts to:

1. Extend the term through June 30, 2021;
2. Reflect adjustments in Health Network's capitation rates and add language reflecting that Directed Payments will be made pursuant to CalOptima Policy and Procedures effective July 1, 2020; and
3. Revise the Shared Risk program attachment in the Shared Risk group contracts to align with changes made to Policy FF.1010 related to the description of the Shared Risk budget.

Background/Discussion

CalOptima currently contracts with 12 health networks to provide care to CalOptima Medi-Cal members. The continued renewal of the contracts will support the stability of CalOptima's contracted provider network. CalOptima's current Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts listed below will expire on June 30, 2020:

Full Risk HMO:
Heritage Provider Network, Inc.
Kaiser Foundation Health Plan, Inc.
Monarch Health Plan, Inc.
Prospect Health Plan, Inc.

Shared Risk:
AltaMed Health Services Corporation
ARTA Western California, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates Inc. of Mid Orange County
Talbert Medical Group, P.C.
United Care Medical Group, Inc.

Physician-Hospital Consortium:
CHOC Physician's Network and Children's Hospital of Orange County
AMVI Care Health Network and Fountain Valley Regional Hospital and Medical Center
Family Choice Medical Group, Inc. and Fountain Valley Regional Hospital and Medical Center

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Staff recommends extending the above Health Network contracts for one year, through June 30, 2021. Extension of the Heath Network contracts is essential to ensuring that members assigned to health networks have access to covered healthcare services.

Health Network Capitation Rate Adjustment

Medi-Cal Classic Rebasing: For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Classic capitation rates effective July 1, 2020, following CalOptima's periodic rebasing process. Rebasing ensures capitation rates paid to our Health Network providers include appropriate reimbursement for medical and non-medical expenses.

Medi-Cal Expansion (MCE) Rates: In 2014, Medi-Cal eligibility was expanded to cover single, low-income individuals ages 19-64, known as Medi-Cal Expansion (MCE). The Department of Health Care Services (DHCS) provided additional funding to support newly eligible MCE members, a group separate from the Medi-Cal Classic member population. Due to the absence of any utilization information at the program's inception, capitation rates for MCE members were set based on assumed population risk from the beginning of the expansion to date.

For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Expansion (MCE) capitation rates effective July 1, 2020. DHCS has applied multiple downward adjustments to CalOptima's MCE capitation rates due to a lower average acuity than first anticipated. As such, staff continues to analyze the appropriateness of MCE capitation rates paid to Health Networks. Based on an actuarial analysis of utilization data, additional reductions to MCE capitation rates are appropriate.

Over the course of the program, sufficient time has passed to compile reliable Chronic Disability Payment System (CDPS) diagnostic information necessary for risk adjustment. With the CDPS information now available to make determinations regarding acuity, staff proposes to amend the current Health Network contracts to adjust the MCE rate, either up or down, based on CDPS data. With margins being reduced, it is more important to implement risk adjustment to ensure capitation payments are commensurate with population acuity. Staff has provided notices to the Health Networks that their MCE capitation rate will be risk adjusted starting July 1, 2020.

OB Kick Payment Rate Increase: Per Policy FF.1005f, CalOptima has historically provided all Health Networks a supplemental payment for qualifying covered obstetric delivery services. The current rates, set in 2010 when the Maternity Kick Payment program began, are $793 for professional services and $4,451 for facility fees. For the new contract term, staff recommends authorization to increase these rates to $900 for professional services and $5,000 for facility fees for all Health Networks, with the exception of Kaiser Health Plan, Inc. which is being reimbursed according to the terms set forth in a March 7, 2019 Board Action.

Directed Payments

Periodically CalOptima is required through DHCS or CMS guidance to make statutorily mandated retrospective payments to its Health Networks. These payments are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF) supplemental payments. In many cases these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years retrospectively, and often based on actual claims paid. Until now, CalOptima has made these DHCS- and CMS- defined supplemental payments to its health networks via contract amendment, as notification came down from the state or federal government. Given the ongoing nature of these payments – including those given under Proposition 56 - multiple amendments, retroactive contract terms, and subsequent timeliness concerns for payment to the impacted providers have been ongoing concerns. To mitigate this, staff recommends that moving forward, Directed Payments be administered according Policy & Procedure FF. 2011 ("Directed Payments"), which addresses Directed Payment programs listed below. Directed Payment is an add-on payment or minimum fee payment required by DHCS to be made to eligible providers for qualifying services (identified below) with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments. As an alternative to requesting authority to amend these contracts on each individual occasion, Policy FF.2011 directs CalOptima to reimburse Health Networks for Direct Payments as they are mandated, pursuant to qualifying services being rendered, providing both policy and procedure guidelines.

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance
Physician Services	7/1/2017 to 12/31/2020	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
Ground Emergency Medical Transport (GEMT)*	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 APL 20-002 released January 31, 2020

**Directed Payments for GEMT Services are not applicable to Shared-Risk Group*

Staff anticipates that Policy FF.2011 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Shared Risk Pool Revisions
Pursuant to a separate Board action, Staff has revised CalOptima Policy FF.1010: Shared Risk Pool to clarify language regarding the Shared Risk pool budget in relation to Coordination of Benefits (COB) recoveries. This revision clarifies that:

1) COB recoveries reduce expense but do not increase revenue; and

2) Since CalOptima is self-insured, reinsurance premium will no longer be allocated to the risk pool.

Fiscal Impact
The recommended actions to enter into amended Medi-Cal Health Network contracts to extend through June 30, 2021, add language reflecting changes to how the Directed Payments are handled, and align Shared Risk group contracts with revisions to CalOptima Policy FF.1010 are not expected to have a fiscal impact.

Costs associated with the recommended action to adjust capitation rates for these contracts, with the exception of Kaiser Foundation Health Plan, Inc., have been included in the proposed CalOptima Fiscal Year (FY) 2020-21 Operating Budget pending Board approval. These proposed changes represent an approximately 2.0% overall reduction in Medi-Cal Classic health network capitation payments, projected at an estimated $8 million in FY 2020-21. In addition, the budget proposes an overall reduction of 7% to the MCE Professional capitation rate and a reduction of 14% to the MCE Hospital capitation rate. Aggregate decreases to MCE Professional capitation expenses and associated shared risk pools are projected to be $50 million in FY 2020-21.

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Action
2. Previous Board Action dated June 6, 2019, Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates
3. Previous Board Action dated December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole Child Model Implementation Date
4. Previous Board Action dated April 2, 2020, Consider Approval of CalOptima Medi-Cal Directed Payments Policy

5. Policy & Procedure FF.2011: Directed Payments
6. Policy & Procedure FF.1005f: Special Payments: Supplemental OB Delivery Care Payment
7. Previous Board Action dated March 7, 2013, Authorize and Direct Chief Executive Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan, (Kaiser)

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into Amended and Restated Full Risk Health Network Contracts with Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. effective July 1, 2019 date that address the following:

a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board in a separate Board action;

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to:

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emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

The budget for Fiscal Year (FY) 2019-20 reflects a decrease in Medi-Cal Expansion (MCE) revenue and an increase in Medi-Cal classic. Capitation reimbursement levels paid by CalOptima to providers for the MCE population is higher than levels that are supported by cost and utilization data. This fact coupled with the reduction in revenue from DHCS has resulted in decreases to the MCE capitation rates for the Health Networks. For the Medi-Cal Classic population Staff recommends an increase to both Professional and Hospital capitation for Adult TANF and SPD members. The amended and restated contract reflects revised capitation rates effective July 1, 2019 to the extent authorized by the Board in a separate Board action.

Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

Costs associated with the recommended action to revise capitation rates for these contracts have been included in the proposed CalOptima FY 2019-20 Operating Budget pending Board approval. The budget includes proposed increases of 4% to the Adult Temporary Assistance for Needy Families (TANF) and seniors and persons with disabilities (SPD) Professional capitation rates and 6% to the Adult TANF and SPD Hospital capitation rates. The increases total approximately $7.5 million in FY 2019-20.

In addition, the budget proposes a reduction of 8% to the MCE Professional capitation rate and a reduction of 21% to the MCE Hospital capitation rate. Aggregate decreases to MCE capitation expenses and associated shared risk pools are projected to be $95 million in FY 2019-20.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

/s/ Michael Schrader — *5/29/2019*

Authorized Signature — **Date**

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
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Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

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[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

ALL PLAN LETTER 19-001
Attachment A

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

Rev. 6/7/2018

        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background
The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

Back to Agenda Back to Item

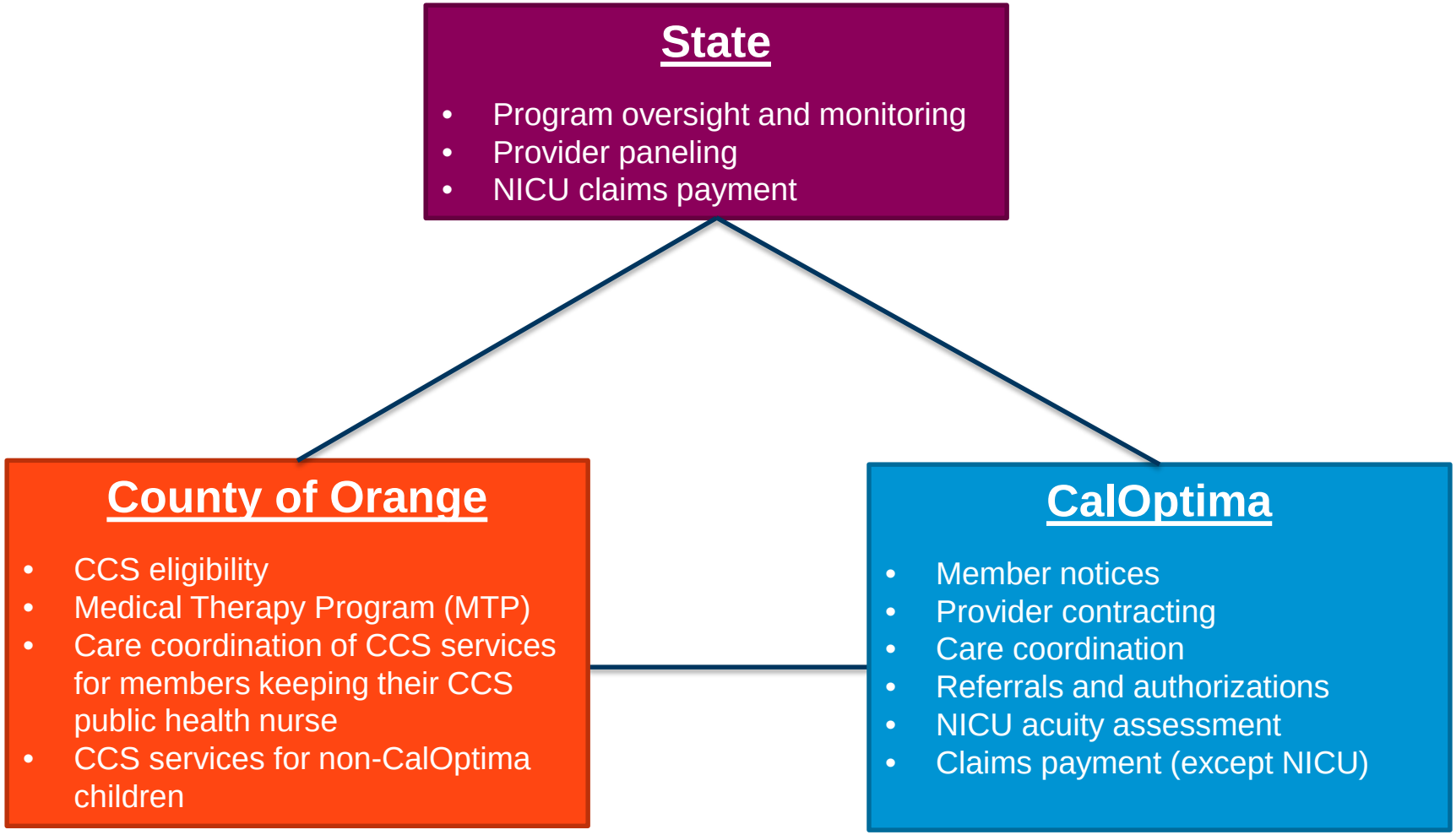
Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency

- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature _____ **Date** _____

Print Name _____

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background
The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

Back to Agenda Back to Item

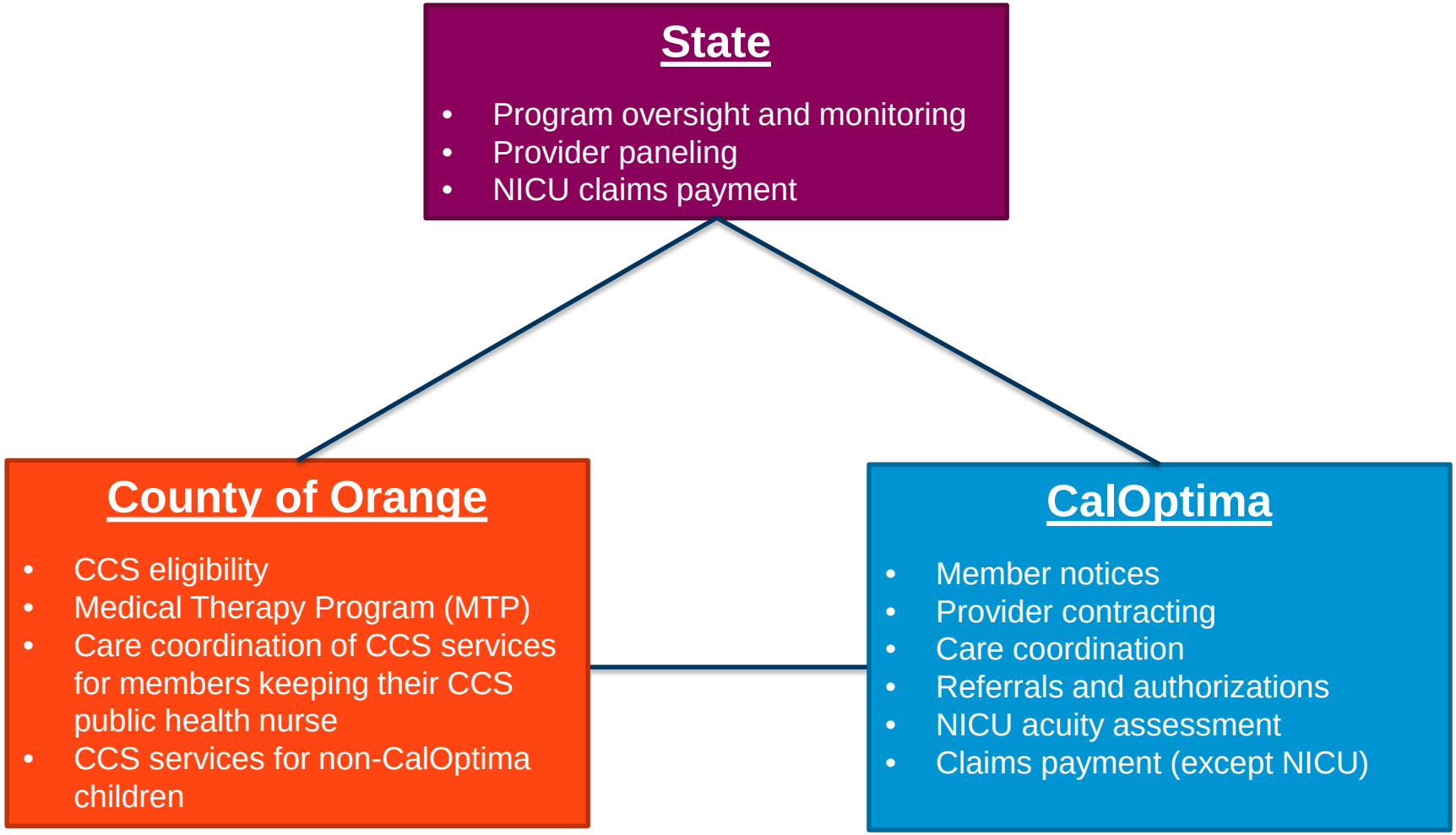
Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency

- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature _____ **Date** _____

Print Name _____

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

Contact

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

Recommended Actions

That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.

4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

Background/Discussion

DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

Fiscal Impact
The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

Policy:	FF.2011
Title:	Directed Payments
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

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7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any

administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday;

         2) After the first birthday and before or on the second birthday; or

3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

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

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

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[1]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[1]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[2]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[2]*Payment obligations for rates of at least $29 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[3]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[3]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[4]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[4]Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

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

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

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

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

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

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

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

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

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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.

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

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

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

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Server:files.medi-cal.ca.gov |File:/pubsdoco/newsroom/newsroom_27057.asp |Last Modified:9/21/2018 5:14:04 PM

Policy:	FF.2011
Title:	**Directed Payments**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	*/s/ Richard Sanchez 04/15/2020*
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

Back to Agenda Back to Item

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

   a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

    a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

    b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

    a. The following Developmental Screening Services are eligible for an Add-On Payment:

        i. A routine screening when provided:

            1) On or before the first birthday;

            2) After the first birthday and before or on the second birthday; or

            3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health

Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

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

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

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/10/2020	Department of Health Care Services (DHCS) [file and use]

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Policy:	FF.1005f
Title:	**Special Payments: Supplemental OB Delivery Care Payment**
Department:	Finance
Section:	Not Applicable
CEO Approval:	/s/ *Michael Schrader 08/08/2019*
Effective Date:	01/01/2010
Revised Date:	07/01/2019

I. PURPOSE

This policy defines the criteria for a **Health Network***, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), to receive a supplemental obstetrical (OB) delivery care payment for qualifying **Covered Services** provided to a **Member** enrolled in Medi-Cal for dates of service on and after January 1, 2010, in accordance with this policy.

II. POLICY

A. Effective for dates of service on and after January 1, 2010, CalOptima shall make a supplemental payment for qualifying **Covered Services** that include OB delivery care at a rate set forth in the **Contract for Health Care Services**, in accordance with the terms and conditions of this Policy.

B. A **Health Network** shall qualify for the supplemental payment for **Covered Services** that include OB delivery care if:

1. On the date of delivery, the **Member** was eligible with CalOptima for less than six (6) consecutive months;

2. On the date of delivery, the **Member** was between fifteen (15) and forty-four (44) years of age;

3. For the physician supplemental OB delivery care payment, **Covered Services** include physician services for normal and C-section delivery and assistant surgeon services billed with any of the following Current Procedural Terminology (CPT) codes: 59400, 59409, 59510, 59514, 59610, 59612, 59618, 59620; and modifier codes AG, or 80, as applicable;

4. For the hospital supplemental OB delivery care payment, **Covered Services** include hospital inpatient services related to an obstetric stay billed with the following Revenue Codes: 720, 721, 722, or 729;

5. The **Health Network** reimbursed the **Provider** for the **Covered Service**;

6. The **Health Network** authorized such services; and

7. The **Health Network** submits **Encounter** data in accordance with Section III.A of this policy.

C. If a **Health Network** identifies an **Overpayment** of a supplemental OB delivery care payment, the **Health Network** shall return the **Overpayment** within sixty (60) calendar days after the date on which the **Overpayment** was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the **Overpayment**. CalOptima shall coordinate with the **Health Network** on the process to return the **Overpayment**.

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

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III. PROCEDURE

A. **Encounter** Data Submission

1. A **Health Network** shall report an **Encounter** in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such **Encounter**.

2. CalOptima shall qualify **Health Network Encounter** Data for valid CPT and Revenue codes, and report the valid **Encounters** for payment authorization.

B. A **Health Network** shall instruct a **Provider** to utilize the appropriate CPT and Revenue codes to bill for **Covered Services** provided to a **Member**.

C. Processing of Physician Claims

1. A **Health Network** shall process an eligible claim submitted by a **Provider** for physician services at a rate set forth in their contractual agreement.

2. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

D. Processing of Hospital Claims

1. **Physician Hospital Consortium (PHC)** or **Health Maintenance Organization (HMO)**

a. A **PHC** or **HMO** shall process an eligible claim submitted by a **Provider** for hospital inpatient services related to an obstetrical stay at a rate set forth in their contractual agreement.

b. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

2. Shared Risk Group (SRG)

a. CalOptima shall process a claim for hospital inpatient services related to an obstetrical stay provided to a **Member** enrolled in an **SRG** in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a **Shared Risk Group.**

b. CalOptima shall make a supplemental payment funding adjustment to the Shared Risk Pool in accordance with Section III.E.1 of this Policy.

E. Hospital Supplemental OB Delivery Care Payment

1. **SRG**: CalOptima shall make a supplemental payment funding adjustment to a Shared Risk Pool at a rate set forth in the **Contract for Health Care Services** for a covered hospital inpatient obstetrical delivery based on actual claims paid in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

2. **PHC** or **HMO**: CalOptima shall make a supplemental payment at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

F. Physician Supplemental OB Delivery Care Payment

1. CalOptima shall make a supplemental payment to a **Health Network** for physician services for normal and C-section delivery and assistant surgeon services at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

G. With the exception of payment funding adjustment to a Shared Risk Pool described in Section III.E.1 of this Policy, CalOptima shall:

1. Distribute physician supplemental payments one (1) time each quarter; and

2. Provide a Remittance Advice Detail (RAD) to the **Health Network** for each quarterly payment that includes the following information:

a. **Provider** name;

b. **Provider** identification number;

c. **Member** name;

d. **Member** identification number;

e. Date of service;

f. Bill code; and

g. Amount paid.

H. A **Health Network** has the right to file a complaint disputing CalOptima's supplemental OB delivery care payment in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
C. CalOptima Policy FF.1010: Shared Risk Pool
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Title 42, Code of Federal Regulations (CFR), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	01/01/2014	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2015	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2016	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	04/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2018	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2019	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. C. Authorize and Direct the Chief Executive Officer to Execute Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan (Kaiser)

Contact

Julie Bomgren, Director, Government Affairs, (714) 246-8400

Recommended Actions

1. Authorize and Direct the Chief Executive Officer (CEO) to execute a three-way agreement with the DHCS and Kaiser related to the transition of Healthy Families Program (HFP) children and Medi-Cal beneficiaries who are former Kaiser members or family-linked within the previous 12 months.
2. Authorize and Direct the CEO to execute an agreement with Kaiser related to transitioning certain defined categories of members to Kaiser as described in the two-way agreement.
3. Authorize and direct the CEO to enter into an amendment of the current Medi-Cal agreement with Kaiser consistent with these agreements.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In 1995, CalOptima entered into an agreement with Kaiser to provide health care services under CalOptima's Medi-Cal program. As a Health Network for Medi-Cal, Kaiser currently provides health care services, including pharmacy services to approximately 11,500 CalOptima Medi-Cal members. Along with CalOptima, Kaiser is a health plan in the HFP and serves approximately 13,500 HFP children in Orange County. With the elimination of HFP, and in accordance with the HFP transition implementation plan, children enrolled in Kaiser HFP will transition to CalOptima in Phase 2, anticipated to occur no sooner than April 1, 2013.

Discussion

In June 2012, the Legislature passed Assembly Bill (AB) 1494 which provides for the transition of all HFP subscribers to Medi-Cal.

In June 2012, Kaiser approached the State to consider the development of an agreement whereby Kaiser will retain its HFP members upon their transition into Medi-Cal through a direct contractual relationship with DHCS. As a direct contractual relationship in the existing managed care county delivery systems throughout California is not possible due to state and federal statutes, DHCS, Kaiser and the Medi-Cal managed care plans developed two agreements to address the HFP transition and future Medi-Cal enrollment.

DHCS/Kaiser/Plan Agreement

The first agreement is, by its own terms, a nonbinding agreement, between DHCS, Kaiser and the managed care plans. This template has already been signed by DHCS and Kaiser. It indicates that it sets forth a framework for a seamless transition of care for current Kaiser members in the HFP and Medi-Cal beneficiaries who were Kaiser members or family-linked within the previous twelve months.

The three-way agreement includes the following provisions:

1. DHCS, Kaiser and managed care plans will work to develop a contract template for the subcontract between plans and Kaiser.
2. A centralized oversight and compliance process to include a uniform policies and procedures audit program will be created to oversee Kaiser's obligations under the contract template (it may be necessary for two processes, one for Northern California and one for Southern California). The agreement indicates that this process will be conducted and funded by DHCS unless otherwise agreed to by the parties.
3. A process will be developed to improve the existing and future enrollment processes for Kaiser members including a validation process (of the applicant's eligibility to choose Kaiser).
4. In COHS counties including Orange County, the enrollment process for current/previous Kaiser members will mimic the existing process for all Medi-Cal members. The COHS plans such as CalOptima will assign to Kaiser new Medi-Cal members currently or previously enrolled with Kaiser in the previous twelve months or family-linked in the previous twelve months. This auto assignment to Kaiser is contingent upon COHS plans receiving required and accurate data from Kaiser and federal and state regulators. COHS members will be assigned to Kaiser only upon verification of previous coverage by Kaiser.
5. The agreement does not restrict the ability of Medi-Cal beneficiaries to choose a different provider than Kaiser during or after the beneficiary has been assigned to CalOptima.

Kaiser/Plan Agreement

The second agreement, between Kaiser and the managed care plan, is titled "Care Continuity Agreement" and defines the beneficiaries for whom the managed care plan will ensure transition to Kaiser as: 1) all members of CalOptima currently assigned to Kaiser; 2) individuals who are eligible for Medi-Cal on and after January 1, 2014 under Medi-Cal expansion and who enroll in CalOptima and are assigned to Kaiser; 3) HFP beneficiaries who are Kaiser members on the effective date of the transition; and 4) beneficiaries who are eligible for Medi-Cal or HFP after the effective date of the transition and who were Kaiser members or family-linked within the previous twelve months. This agreement has been signed by Kaiser but does not include aid codes on the attachments.

The two-way agreement includes the following provisions:

1. Kaiser will provide rate development template (RDT) data to managed care plans for inclusion in the plan RDT for the rate setting process.

2. Effective July 1, 2013, for aid codes not directly funded through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), an administrative withhold by the managed care plan will not exceed 2% of the net capitation Medi-Cal amount (the withhold may be based on the plan risk-adjusted equivalent of the net capitation amount). For aid codes directly funded through CHIPRA, there will be no administrative fee withhold.
3. Managed care plan contracts with Kaiser will be amended to include these provisions. However this Agreement indicates that it may be terminated only upon execution of an amendment to the parties, and that the terms of this Agreement will be re-evaluated in five years.
4. Kaiser may enter into a direct contract with DHCS if Kaiser is unable to reach a subcontracting agreement with Plan.

Upon approval by the Board of Directors, CalOptima modified its Medi-Cal auto assignment policy to accommodate the transition of HFP members and to the extent possible, preserve the provider/member and member/health network relationships. For children transitioning from other HFP health plans to Medi-Cal, CalOptima anticipates that DHCS will provide the Medi-Cal health plan a file that will include the incoming health plan code and name for transitioning HFP children. In order to ensure a seamless transition of care for Kaiser members, it will be necessary that CalOptima receive a timely, clean file for processing. Otherwise, CalOptima staff will follow our standard new member auto assignment process.

Fiscal Impact
With Kaiser's current membership, the 2% administrative withhold provision equates to approximately $250,000 annually which is one-half of the amount regularly included in DHCS capitation rates for administration. However, as an HMO, Kaiser will perform some of the functions that CalOptima would normally be responsible for, which will reduce CalOptima's cost accordingly.

Rationale for Recommendation
These template agreements were negotiated with DHCS, Kaiser and managed care plans and the provisions for transitioning HFP members are consistent with the requirements included in the recent amendment to CalOptima's Primary Agreement with DHCS related to the transition of HFP subscribers into Medi-Cal.

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

Attachments
None

/s/ Michael Schrader — *3/1/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

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

Recommended Actions
1. Authorize Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020;

2. Authorize waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect;

3. Authorize unbudgeted expenditures from existing reserves of up to $14 million to provide funding for rates adjustments for Health Network capitation rates;

~~4. Authorize interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020;~~ Amended 4/2/20

5. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

    a. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and
    b. Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application.

Background
On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

As an unprecedented safety measure, the state has issued self-quarantine and social distancing requirements for an unknown period of time. These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops. One immediate downstream effect of these measures has been CBAS closures as a result of a reduction of in-person utilization. Left

unaddressed, this can rapidly jeopardize the viability of CalOptima's CBAS provider network. Moreover, it underscores the need for CalOptima to take necessary measures to ensure there is limited disruption of care and access to services for our members, which includes vulnerable individuals.

Discussion

CalOptima management recognizes that healthcare service delivery to our members has undergone significant changes during the coronavirus pandemic. Management recommends the following actions in order to provide immediate aid and service authorization flexibilities to CalOptima's provider network in order to ensure that members received access to covered, medically necessary health care services:

Medi-Cal Rate Enhancement for Health Networks

To provide immediate aid and support and maintain the viability of the health networks, Management proposes to:

1. Provide a 5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates for the period of April 1, 2020, through June 30, 2020. The estimated aggregate monthly fiscal impact is approximately $4.4 million.

2. Amend the Medi-Cal Health Network contracts to reflect this increase for the period stated above.

Special Reimbursement to CBAS providers

Staff anticipates face-to-face visits at CBAS centers to continue decreasing due to the Governor's stay at home executive order issued on March 19, 2020, and the County of Orange's social distancing requirements. CalOptima currently holds contracts with 31 CBAS centers, serving approximately 2,580 members. Preventing this is critical at this time, as CBAS centers serve CalOptima's most vulnerable senior members On March 19, 2020, the California Department of Health Care Services (DHCS) submitted a request for additional Section 1135 Waiver flexibilities related to coronavirus. This request included additional flexibilities related to the CBAS benefit and individual plan of care. In order to continue uninterrupted access to CBAS services, effective March 13, 2020, Management proposes to:

1. Waive the 1115 waiver requirement of a minimum of a four-hour stay at the center. This change will enable CalOptima members to receive appropriate services at home and remove barriers to access.

2. Expand the types of services eligible for per diem payments. Pursuant to DHCS' 1135 Waiver request, CalOptima will provide per diem payments to CBAS providers who provide:
   - Telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments;
   - Arrange for home delivered meals in absence of meals provided at the CBAS center; and/or
   - Provide physical therapy or occupational therapy in the home

3. Amend CBAS contracts to reflect the waiver of the minimum four-hour stay requirement and expansion of services pursuant to DHCS 1135 Waiver request.

~~Interim Medi-Cal Rate for Coronavirus Testing~~

~~The Centers for Medicare & Medicaid Services (CMS) established, for the Medicare program, procedure codes and provider reimbursement rates for coronavirus testing conducted on or after February 4, 2020. DHCS adopted these same procedure codes for the Medi-Cal program effective February 4, 2020. As of this writing, DHCS has not established Medi-Cal reimbursement rates for coronavirus testing.~~ Amended 4/2/20

~~Management proposes to adopt the Medicare provider reimbursement rates on an interim basis for CalOptima's Medi-Cal program for dates of service on or after February 4, 2020. Once DHCS establishes Medi-Cal reimbursement rates for coronavirus testing, CalOptima will make retroactive adjustments to Medi-Cal claims, as appropriate.~~ Amended 4/2/20

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5% of total medical capitation expenditures, in aggregate, in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Staff projects the monthly incremental funding at approximately $4.4 million. An allocation of up to $14 million from existing reserves will fund this action.

The CalOptima FY 2019-20 Operating Budget includes funding for Professional medical expenditures for contracted CBAS providers. Currently, the net fiscal impact for the recommended action is unknown. However, assuming current utilization levels will continue, Staff anticipates the recommended action will not have an additional fiscal impact to the operating budget.

~~The fiscal impact for the recommended action to authorize an interim Medi-Cal rate for coronavirus testing is unknown at this time, since both utilization and costs estimates are difficult to quantify. However, Staff anticipates future funding received from DHCS for this purpose will fully offset expenses incurred by CalOptima.~~ Amended 4/2/20

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency dated March 19, 2020

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

03/26/2020 — **Date**

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 19, 2020

Jackie Glaze
CMS Acting Director
Medicaid & CHIP Operations Group Center for Medicaid & CHIP
Services 7500 Security Boulevard
Baltimore, MD 21244
Jackie.Glaze@cms.hhs.gov

REQUEST FOR ADDITIONAL SECTION 1135 WAIVER FLEXIBILITIES RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY/PUBLIC HEALTH EMERGENCY

Dear Ms. Glaze:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). These flexibilities are in addition to the request submitted from DHCS on March 16, 2020. As you know, the COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The below list represents California's additional requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency based on further exploration of need. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHCS may subsequently request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, DHCS requests a retroactive effective date of January 27, 2020, for the requested Section 1135 flexibilities to coincide with the effective start date of the Public Health Emergency, unless otherwise specified. In the event a requested flexibility below is not approvable under the Section 1135 authority, DHCS requests CMS technical assistance to identify any other authority (e.g. under the State Plan or Section 1115) for which approval may be available. Per our discussion with CMS on March 19, 2020, DHCS will request the flexibilities associated with Inmate and Institutions for Mental Disease (IMD) funding exclusions in the Section 1115 context (according to the forthcoming CMS instructions/Section 1115 template).

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In addition, DHCS requests confirmation that any approved flexibility granted with respect to fee-for-service Medi-Cal benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, such as Medi-Cal managed care plans (MCPs), county organized health systems, county mental health plans, and Drug Medi-Cal organized delivery systems (DMC-ODS) and to the State's standalone Children's Health Insurance Program.

1. **Service authorization and utilization controls**, including but not necessarily limited to:

- Waiver of Attachment 3.1 – A.1, page 2 of the State Plan, exclusion of adult receipt of acetaminophen-containing and cough/cold products.

- For individuals with developmental disabilities receiving services under the State Plan 1915(i) authority, the state requests retainer payments. Retainer payments are available only for absences (maximum 30 consecutive days) in excess of the average number of absences experienced by the provider during the 12 month period prior to 2020.

- For Community-Based Adult Services (CBAS) – CBAS Benefit and Individual Plan of Care (IPC), the state requests:
    - Flexibility to reduce day center activities/gatherings and limit exposure to vulnerable populations.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face social/therapeutic visits.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face assessments.
    - Flexibility to allow following services to be provided at a beneficiary's home:
        - Physical Therapy
        - Occupational Therapy
    - Flexibility to provide or arrange for home delivered meals in absence of meals provided at the CBAS Center.
    - Flexibility for DHCS and MCPs to provide per diem payments to CBAS providers who provide telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments, arrange for home delivered meals in absence of meals provided at the CBAS Center, and/or provide physical therapy or occupational therapy in the home.

2. **Eligibility Flexibilities**, including but not necessarily limited to:

    - Flexibility in the hospital presumptive eligibility (HPE) program to cover more than one HPE period in a given 12-month timeframe. To the extent a beneficiary seeks care for coronavirus but has already used an HPE period in the last 12 months, or tests negative and then seeks care for a suspected episode later in the same 12-month period, HPE can provide a fast, low-barrier way to provide immediate, temporary coverage during the emergency period.

3. **Telehealth/Telephonic/Virtual Visits**, including but not necessarily limited to:

    - Waiver of 42 C.F.R. §438.6(c)(1), as necessary, to permit the State to direct MCO and PIHP payments to network providers, where telehealth/telephonic service is medically appropriate and feasible, at the same rate the MCO or PIHP would pay if the service was provided in person, unless the MCO/PIHP and the provider otherwise agree to a different rate for the telehealth modality.

    - Similar to flexibility granted at the federal level, DHCS requests authority for the State not to impose penalties for noncompliance with the regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA) against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 emergency.

4. **Administrative Activities**, regarding deadlines and timetables for performance of required activities, DHCS requests extension of time for activities conducted by the state, MCPs, and/or county mental health and substance use disorder prepaid inpatient health plans (PIHPs), as applicable, due to social distancing to reduce the spread of COVID-19 and to allow the state, MCP, and/or PIHP resources to prioritize COVID-19 response efforts including:

    - Waiver of the two-year claiming submission limit (42 USC §1320b-2; 45 CFR §95.1, et seq.) for federal financial participation or claiming adjustments with respect to medical assistance and administrative expenditures.

    - Waiver of the requirement in 42 CFR §447.45(d)(1), that DHCS require providers to submit all claims no later than 12 months from the date of service. DHCS is requesting authority to extend the 12-month timeframe for services provided with dates of service during this emergency.

    - Modification of the federal deadlines for submission of cost reports for Medicare and Medicaid (currently due Nov. 2020) by at least 6 months, with no late penalties, so that providers have time to file the appropriate documents. Many provider and hospital staff have been told to work remotely or have been reassigned to

emergency response activities, which will cause delays in meeting reporting timelines.

- Waiver of the timeframe required for financial oversight and medical compliance audits for PIHPs and State Plan Drug Medi-Cal counties. DHCS requests this waiver to allow flexibility regarding deploying staff resources to manage the emergency.

5. **Payment Rates**, including but not necessarily limited to:

- Waiver of the county interim rate setting methodology described beginning on page 10 of the Certified Public Expenditure (CPE) protocol approved through the 1915(b) waiver. The CPE protocol requires DHCS to calculate county interim rates using prior year cost reports trended forward using the Home Health Agency Market Basket Index or a CMS approved cost of living index. As utilization drops and costs increase during this emergency, DHCS is requesting authority to use alternative methodologies, at DHCS's discretion, to temporarily increase county interim rates.

- Waiver of the interim rate setting methodology described on page 5 and 6 of the Drug Medi-Cal Organized Delivery System (DMC ODS) Certified Public Expenditure protocol approved through the 1115 demonstration. The CPE protocol requires DHCS to reimburse DMC ODS counties on an interim basis pursuant to county developed and DHCS approved interim rates for each service, which are expected to be based upon the most recently calculated or estimated county costs for the specific service. DHCS is requesting authority, if counties reimburse DMC providers up to actual cost, to reimburse counties the federal and state share of their certified public expenditures for services rendered during this emergency.

- Waiver of the Statewide Maximum Allowance (SMA) rate limitation on interim reimbursement and final settlement for Drug Medi-Cal (DMC) services provided in state plan counties. California's State Plan describes the reimbursement methodology for DMC services in Attachment 4.19-B, pages 38-41b (SPA 09-022 and SPA 15-013), which limits interim payments to DMC providers to the lower of the SMA or the USDR (Section E.1, page 41). Furthermore, the Medicaid State Plan also limits final reimbursement to lower of actual cost, usual and customary charges, or the SMA for DMC providers. DHCS is requesting authority to waive the SMA and usual and customary charge limitations on interim and final reimbursement for DMC state plan services.

6. **Clarification of Previous Requests**:

- Item 2 in the March 16, 2020 1135 Waiver requested to waive various federal and State Plan requirements pertaining to service authorization and utilization controls

imposed on covered benefits. DHCS seeks to clarify that the requested waivers would extend to any limitations for elective procedures and informed consent (including, but not necessarily limited, to 42 C.F.R. § 441.253) to enable provider to postpone elective procedures to prioritize COVID-19 response activities. DHCS suggests extending the current 180-day limit for beneficiary informed consent to 360 days.

- Item 5 in the March 16, 2020 1135 Waiver requested to waive restrictions existing restrictions on individual counseling sessions under the Drug Medi-Cal state plan. DHCS wants to clarify that we are requesting to waive Supplement 3 to Attachment 3.1-B, to allow individual visits in lieu of group visits, and that these visits may be conducted by telephone, telehealth, and/or in-person. Waive the current restriction on individual visits (only allowed for intake, crisis intervention, collateral services, and treatment and discharge planning). Allow individual visits to be used for counseling focused on short-term personal, family, job/school and other problems and their relationship to substance use. This waiver is needed so the services previously provided in groups can be done in individual sessions during the emergency, to prevent COVID-19 exposure.

- Item 6 in the March 16, 2020 1135 Waiver requested to waive State Plan Attachment 4.19-D, including any applicable Supplements, which establishes the payment methodology for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and skilled nursing facilities (SNFs). The state wanted to clarify that the waiver being requested would apply to all SNF and ICF-DD facility types and the reimbursement flexibilities would not be limited solely to the costs associated with suspension of Day Programs. SNFs and ICF-DDs are experiencing increased cost pressures in a variety of areas as a result of the COVID-19 response and the state is seeking flexibility to allow consideration of all costs being incurred by facilities to ensure the health and safety of residents.

7. Flexibilities to be Requested under Section 1115 Authority (according to forthcoming CMS guidance):

- Waiver of the inmate exclusion (42 U.S.C. §1396d(a)(30)(A)) to allow for Medi-Cal claiming for services provided ***in*** jails and prisons for the testing, diagnosis and treatment of COVID-19 or services to ensure other care is provided in a safe way without transporting individuals to acute care facilities.

- Waiver of the 16-bed limitation/prohibition on receipt of federal financial participation for patients residing in Institutions for Mental Disease (IMD) pursuant to 42 U.S.C. §1396d(a)(30)(B). DHCS believes waiver of the IMD exclusion is necessary to temporarily increase bed capacity for affected beneficiaries and to allow facilities to claim for services provided for these

additional beds. Evaluation of less restritictive settings would be completed prior to placement.

During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership.

Sincerely,
Original Signed By:

Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

cc: Bradley P. Gilbert, MD, MPP
Director
Department of Health Care Services

Erika Sperbeck
Chief Deputy Director
Policy & Program Support
Department of Health Care

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Ratify amendments to the Medi-Cal health network contracts, except AltaMed Health Services Corporation, to include payment by CalOptima of startup costs associated with the Whole-Child Model program; and,
2. Ratify the expenditure of up to $1.75 million in IGT 6 and 7 funds for implementation.

Background

The California Children's Services Program (CCS) is a statewide program, providing medical care, case management, physical/occupational therapy, and financial assistance for children up to age 21 meeting financial and health condition eligibility criteria. Following the approval of Senate Bill 586 in September 2016, the Department of Healthcare Services (DHCS) was given the authority to incorporate a number of CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS), referred to as the Whole Child Model (WCM). CalOptima began the process of transitioning its Medi-Cal Health Networks in June 2018, with implementation going live as of July 1, 2019. The importance of a successful WCM transition cannot be overstated, as it directly impacts the wellbeing of CalOptima's most at-risk pediatric members.

IGTs are transfers of public funds between eligible governmental entities, which qualify for matching federal funds for the Medi-Cal program. IGT 6 and 7 funds were received in May 2018 from the Department of Health Care Services (DHCS) totaled $31.1 million. After initial disbursements of $10 million for the Homeless Health Initiative, the Board authorized the remaining balance of $21.1 million to be used for community grants, internal initiatives and program administration. On August 1, 2019, the Board authorized $1.75 million for the Whole Child Model Assistance for Implementation and Development (WCM AID), which was approved as an internal initiative. The funds were designated to aid health networks in developing and implementing a successful delivery system for the WCM program.

Discussion

Health networks were required to cover a portion of the WCM program's startup expenses incurred before the launch on July 1, 2019. Following the Board's August 1, 2019 approval of the IGT 6 and 7 allocation for WCM startup costs, health networks were notified that they would receive a one-time, fixed payment of $50,000, plus applicable variable costs up to the amount allowed per network based on the number of WCM assigned members. CalOptima provided criteria for reimbursement, including

receipt of attestations demonstrating that the costs were incurred prior to the WCM program go-live date of July 1, 2019, and that expenditures fall within the specified categories of:

- Staffing, recruitment and training.
- Systems and infrastructure.
- Other expenses such as educational materials, notices, etc.

Staff seeks authority to ratify contract amendments and expenditures for the Medi-Cal health networks, except AltaMed Health Services Corporation, to aid with start-up costs and implementation of the WCM program.

Fiscal Impact

The recommended action to amend Medi-Cal health network contracts to include disbursement of IGT 6 and 7 funds for WCM Assistance for Implementation and Development has no fiscal impact to CalOptima's operating budget. The Board authorized the allocation of $1.75 million from IGT 6 and 7 funds for this purpose at the August 1, 2019, meeting. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

The recommended action ensures CalOptima's Medi-Cal health network contracts are updated to reflect receipt of IGT 6 and 7 funds for reimbursement of startup costs associated with the WCM program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 3, 2017; Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot
3. Previous Board Action dated August 1, 2019; Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

/s/ Michael Schrader — *02/26/2020*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Health Network	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CalOptima Community Network	505 City Parkway West	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Ave, #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
Orange County Health Care Agency	405 W. 5th St.	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. The IGT funds are to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program. Consequently, these funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

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Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal plan for Orange County is committed to continuing to work with our provider and community partners to address gaps and work to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

/s/ Michael Schrader *7/27/2017*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
14. Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

Contact
Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions
1. Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1 million for community grants and internal projects; and,
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into grant contracts with the recommended community grantees.

Background
Intergovernmental Transfers (IGTs) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT 1 – 7 funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus IGT 1-7 funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries. Beginning with IGT 8, the IGT funds are viewed by the state as part of the capitation payments CalOptima receives; these payments are to be tied to covered Medi-Cal services provided to Medi-Cal beneficiaries.

On August 3, 2017, CalOptima's Board of Directors approved the recommendation to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

Subsequently, CalOptima released Requests for Information/Letters of Interest (RFI/LOI) from organizations to help determine funding allocation amounts for the priority areas and received 117 responses. Initial projections of available IGT 6/7 funds were estimated to be $22.1 million.

In May 2018, CalOptima received final IGT 6 and 7 funding from the Department of Health Care Services (DHCS), resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. On August 2, 2018, the Board approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program. On September 6, 2018 the Board authorized the remaining available balance of $21.1 million to be used for community grants, internal initiatives and program administration.

Subsequently, at its February 22, 2019 Special Meeting, the Board approved funds to be reallocated to the Clinical Field Teams Pilot for the Homeless Health Initiatives. The funds were reallocated from Requests for Proposals (RFP) 4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) in the total amount of $1 million which were not recommended for grants. In addition, $100,000 IGT 6 funds previously approved by the Board were reallocated from Internal Initiatives to the Clinical Field Teams Pilot. The reallocations were ratified at the April 4, 2019 Board meeting.

Proposed Allocation for community grants and internal initiatives is as follows:

Community Grants

Request for Proposal	Priority Area	Allocation Amount
1. Access to Outpatient Mental Health Services	Children's Mental Health	$4,850,000
2. Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	$4,850,000
3. Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000
4. Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
5. Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA	$1,000,000
6. Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
TOTAL		**$16,700,000**

Internal Initiatives

Internal Project Examples: - IS and other infrastructure projects as summarized below.	$2,400,000
TOTAL	**$2,400,000**

External subject matter experts and staff performed an examination of the RFP responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do and Director DiLuigi, met to discuss the results of the 54 RFP responses for the Children's Mental Health and Opioid and Other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the evaluation committees results and RFP recommendations, the Ad Hoc committee is recommending the following allocation of approximately $16.7 million for IGT 6 and 7 Board-approved priority areas through four (4) RFPs.

Community Grants

Category	Organization	Funding Amount
RFP 1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)	Children's Bureau of Southern California	$3,390,000
	OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$685,000
	Boys & Girls Clubs of Garden Grove	$325,000
	Jamboree Housing	$450,000
RFP 2. Integrate Children's Mental Health Services into Primary Care ($4.85 million)	CHOC Children's	$4,250,000
	Friends of Family Health Center	$600,000
RFP 3. Increase Access to Medication-Assisted Treatment ($6 million)	Coalition of Orange County Community Health Center	$6,000,000
RFP 5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)	Serve the People	$1,000,000
TOTAL		**$16,700,000**

As noted above, the ad hoc is not recommending grants for two of the RFP categories (4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) and the associated funding was previously reallocated to the Clinical Field Teams Pilot at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

Internal Initiatives
In addition, staff reviewed four internal applications and is recommending an allocation of $2.4 million for internal projects. Funding of $100,000 from the Internal Initiatives budget was reallocated to the Clinical Field Team pilot for the Homeless Health Initiatives at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

Project	Amount
Whole Child Model Assistance for Implementation and Development (WCM AID)	$1,750,000
Master Electronic Health Record (EHR) System	$650,000
TOTAL	**$2,400,000**

Fiscal Impact
The recommended action to approve the allocation of $19.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, will work with our provider and community partners to address the health care needs of the members we serve.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: IGT 6 and 7 Expenditure Plan Allocation
2. CalOptima Board Action dated August 3, 2017, Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7
3. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Fund
4. CalOptima Board Action dated September 6, 2018, Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals (RFPs) for Community Grants
5. CalOptima Board Action dated February 22, 2019, Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but no limited to, Funding and Provider Contracting
6. IGT 6/7 RFP Responses

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

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CalOptima
A Public Agency
Better. Together.

IGT 6 and 7 Community Grant Award Recommendations

August 1, 2019

Candice Gomez
Executive Director, Program Implementation

Background

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGTs 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
  - IGTs 8–9: Funds must be used for Medi-Cal covered services for the Medi-Cal population
- CalOptima Board of Directors approved IGT 6 and 7 priority areas for community-based funding opportunities
  - Children's Mental Health
  - Homeless Health
  - Opioid and Other Substance Overuse
  - Other Needs Identified by the Member Health Needs Assessment

Background (cont.)

- Received 117 RFIs to identify strategies for each priority area
- IGT 6 and 7 funds of $31.1 million were received in May 2018
  - $10 million approved for recuperative care services in August 2018
  - $21.1 million allocated for community grants, internal initiatives and program administration in September 2018
    - $17.7 million in community grants
    - $2.5 million in internal initiatives
    - $900,000 in program administration (over 3 years)
- Released RFPs, evaluated responses and conducted site visits from September 2018–January 2019

RFP Evaluation Criteria

- Organizational capacity and financial condition
- Statement of need that describes the specific issue or problem and the proposed program/solution
- Impact on CalOptima members with outreach and education strategies
- Efficient and effective use of potential grant funds for proposed program/solution

Site Visits

- Subject matter experts and staff conducted site visits to finalist organizations
- Questions were asked to:
  - Better understand the organization, current services provided and the proposed project
  - Identify the organization's leadership capacity and skills to effectively provide the proposed services
  - Determine if there are any concerns with awarding a grant to the organization

RFP Summary

RFP	Total Received	Total Recommended
1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)	26	4
2. Integrate Children's Mental Health Services Into Primary Care ($4.85 million)	10	2
3. Increase Access to Medication-Assisted Treatment ($6 million)	10	1
4. Expand Mobile Food Distribution Services ($500,000)	1	0
5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)	5	1
6. Expand Access to Food Distribution Services for Older Adults ($500,000)	2	0
Total	**54**	**8**

1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Children's Bureau of Southern California	$3,500,000	$3,390,000
2	OCAPICA (Orange County Asian & Pacific Islander Community Alliance Inc.)	$685,000	$685,000
3	Boys & Girls Club of Garden Grove	$325,200	$325,000
4	Jamboree Housing	$692,000	$450,000
	Total	**$5,202,200**	**$4,850,000**

2. Integrate Children's Mental Health Services Into Primary Care ($4.85 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	CHOC Children's	$4,785,076	$4,250,000
2	Friends of Family Health Center	$600,000	$600,000
	Total	**$5,385,076**	**$4,850,000**

3. Increase Access to Medication-Assisted Treatment ($6 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Coalition of Orange County Community Health Centers	$5,998,000	$6,000,000
	Total	**$5,998,000**	**$6,000,000**

5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Serve the People	$1,000,000	$1,000,000
	Total	**$1,000,000**	**$1,000,000**

No Funding for RFPs 4 and 6

- No funding is recommended for two RFPs
  - 4. Expand Mobile Food Distribution Services ($500,000)
  - 6. Expand Access to Food Distribution Services for Older Adults ($500,000)
- Submitted proposals presented challenges
  - Did not demonstrate delivery of service to CalOptima members
  - Did not demonstrate sustainability after funds exhausted
- Funding was allocated to the Homeless Health Initiative's Clinical Field Team pilot on February 22, 2019

Internal Projects ($2.4 million)

Rank	Project	Original Request	Recommended Funding Amount
1	Whole-Child Model Assistance for Implementation and Development	$1,750,000	$1,750,000
2	Master Electronic Health Record (EHR) System	$700,000	$650,000
	Total	**$2,450,000**	**$2,400,000**

Recommended Board Actions

- Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1M for community grants and internal projects; and,
- Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contracts with the recommended community grantees.

CalOptima's Mission

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


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

IGT Update & Proposed Funding Categories for IGT 6 & 7

Board of Directors Meeting

August 3, 2017

Cheryl Meronk

Director, Strategic Development

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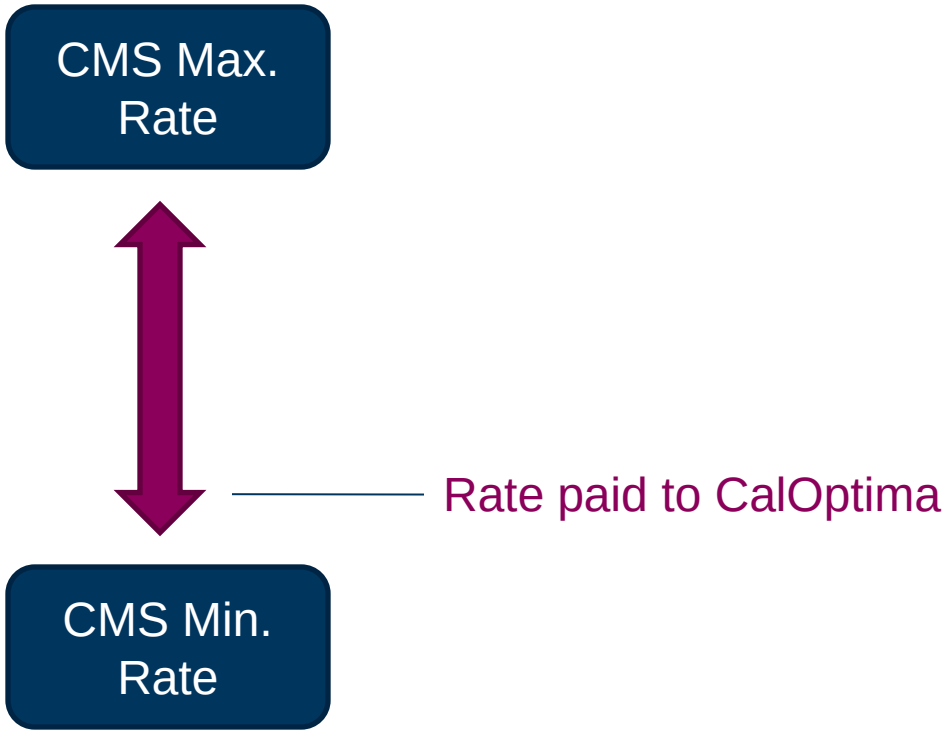
Intergovernmental Transfers (IGT) Background

- Medi-Cal program is funded by state and federal funds
- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
- Funds must be used to deliver enhanced services for the Medi-Cal population

Low Medi-Cal Managed Care Rates

- CMS approves a rate range for Medi-Cal managed care
- California pays near the bottom of the range



IGT Funds Availability and Process

- Available pool of dollars based on difference paid to CalOptima and the maximum rate
- Access to IGT dollars is contingent upon eligible government entities contributing dollars to be used as match for federal dollars
- Funds secured through cooperative transactions among eligible governmental funding entities, CalOptima, DHCS and CMS

CalOptima Share Totals To-Date

IGTs	CalOptima Share
IGT 1	$12.52 M
IGT 2	$8.60 M
IGT 3	$4.88 M
IGT 4	$6.97 M
IGT 5	$14.42 M
Total	**$47.39 M**

IGT 1 Status

Project	Budget	Balance	Notes
Personal Care Coordinators	$3,850,000	$0	Completed
Case Management System	$2,099,000	$0	Completed
Strategies to Reduce Readmissions	$533,585	($77,836)	Completed
Program for High-Risk Children	$500,000	$481,440	*Complete by 12/31/2018*
Case Management System Consulting	$866,415	$16,320	*Complete by 12/31/2017*
OCC PCC Program	$3,550,000	$0	Completed
Reallocated	*$1.1 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Total	**$11.4 M**	**$0.5 M**	

As of 5/31/2017

IGT 2 Status

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	$1,756,620	$0	Completed
Security Audit Remediation	$98,000	$0	Completed
Continuation of COREC	$970,000	$186,745	*Complete by 10/31/2018*
OCC PCC Program	$2,400,000	$2,400,000	*Complete by 3/31/2018*
Children's Health/ Safety Net Services	$1,300,000	$25,875	*Complete by 9/30/2017*
Wraparound Services	$1,400,000	$448,400	*Complete by 6/30/2018*
Recuperative Care	$500,000	$146,300	*Complete by 12/31/2018*
Program Administration	$100,000	$0	Completed
PACE EHR System	$80,000	$0	Completed
Total	**$8.6 M**	**$3.2 M**	

As of 5/31/2017

IGT 3 Status

Project	Budget	Balance	Notes
Recuperative Care (Phase 2)	$500,000	$500,000	*Complete by 12/31/2018*
Program Administration	$165,000	$70,885	*Complete by 12/31/2017*
Reallocated	*$4.2 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Remaining Total	**$0.7 M**	**$0.6 M**	

As of 5/31/2017

IGT 4 Status

Project	Budget	Balance	Notes
Data Warehouse Expansion	$750,000	$553,588	*Complete by 3/31/2018*
Depression Screenings	$1,000,000	$1,000,000	*Complete by 3/31/2019*
Member Health Homes	$250,000	$250,000	*Complete by 12/31/2017*
Member Health Needs Assessment	$500,000	$479,805	*Complete by 12/31/2017*
Personal Care Coordinators	$7,000,000	$6,982,240	*Complete by 6/30/2018*
Provider Portal Communications & Interconnectivity	$1,500,000	$1,472,480	*Complete by 12/31/2018*
UCI Observation Stay Payment Pilot	$750,000	$750,000	TBD
Program Administration	$529,608	$510,428	*Complete by 12/31/2018*
Reallocated	*$0*	*$5.3 M*	*Dollars reallocated from IGTs 1 & 3 (included in IGT 4 total)*
Total	**$12.3 M**	**$12.0 M**	

As of 5/31/2017

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IGT 5

- $14.4M allocated for competitive community grants
- Community grant initiatives to be developed, pending results from CalOptima's Member Health Needs Assessment

- Funding Categories:
  - Adult Mental Health
  - Children's Mental Health
  - Strengthening the Safety Net
  - Childhood Obesity
  - Improving Children's Health

Member Health Needs Assessment (IGT 5)

- Builds upon previous surveys and assessments, e.g.
  - CalOptima Group Needs Assessment
  - OC Health Care Agency – OC Health Profile
  - Hospital Community Needs Assessments
- Deeper focus on needs of diverse, underserved Medi-Cal membership, including:
  - 7 threshold languages + others never previously represented
  - Homeless
  - Mentally ill
  - Older adults
  - Persons with disabilities

Member Health Needs Assessment (IGT 5)

- Comprehensive assessment to identify gaps in and barriers to service
  - Access to PCPs, specialists & hospitals
  - Pharmacy and lab
  - Oral health services
  - Mental health services
- Insights into social determinants of health
  - Economic stability/employment status
  - Housing status
  - Education/literacy level
  - Social isolation
  - Transportation issues
  - Cultural differences
  - Communication barriers

Estimated IGT 6 and 7 Totals

IGT	CalOptima Share
IGT 6	≈ $9.95 M (Anticipated December 2017)
IGT 7	≈ $12.16 M (Anticipated May 2018)
Total	**≈ $22.11 M**

Proposed IGT Funding Categories - IGT 6 and 7

- Funds to be used to deliver enhanced services for the Medi-Cal population

Opioid/Other Substances Overuse

- Nationwide, 78 opioid overdose deaths per day
  - 45% of Rx drug overdose deaths are Medicaid beneficiaries
- In OC, 286 opioid-related drug overdose deaths in 2016
  - Opioid dependence second leading cause of substance-related hospitalizations in OC after alcohol dependence syndrome

- Potential solutions to be funded:
  - Expand access to pain management, addiction treatment and recovery services
  - Outreach and education
  - Technical assistance to community groups working to reduce opioid and other substance overuse

Children's Mental Health

- Estimated 52,500 OC youth living with a mental health condition
- Hospitalization rate for major depression among children and youth continues to rise
- Only 32 psychiatric acute care beds in OC for adolescents, and zero for children under 12
  - New CHOC facility will add 18 beds, for ages 3-18

- Potential solutions to be funded:
  - Expand inpatient and outpatient psychiatric services capacity for children 3-18

Homeless Health

- Homelessness in OC on the rise
  - 2017 Point-in-Time count identified 4,792 homeless individuals
  - 2015 Point-in-Time count was 4,452
  - As of 2015, estimated 15,291 homeless individuals in OC
    - Approximately 11,000+ of these are CalOptima members
- Economic impact of homelessness ≈ $300M over 12-month period between 2014-15
  - Includes $121M for health care costs
- Potential solutions to be funded:
  - Expand recuperative care services
  - Increase/expand mobile health clinics

Competitive Community Grants

- Funding to fill gaps and address barriers to service beyond IGT 5 funding categories:
  - Examples of possible additional priority areas:
    - Older Adult Health
    - Dental Health
    - Persons with Disabilities
    - Maternal/perinatal Health

CalOptima Projects and Program Admin

- Approx. 10% of total IGT 6 & 7 set aside for internal priorities and program administration, e.g.:
  - Expansion of provider electronic records capabilities
  - IGT program administration
  - Grant development and administration

Next Steps

- Gather stakeholder input
  - PAC
  - MAC
  - OCC MAC
  - Community organizations
- Develop expenditure plans for Board approval

CalOptima's Mission

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. The IGT funds are to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program. Consequently, these funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

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Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal plan for Orange County is committed to continuing to work with our provider and community partners to address gaps and work to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

/s/ Michael Schrader *7/27/2017*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

Contact
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Approve an additional grant allocation of up to $10 million to the Orange County Health Care Agency (OCHCA) from the Department of Health Care Services-approved and Board-approved Intergovernmental Transfer 6 and 7 Homeless Health priority area;
2. Replace the current cap of $150 on the daily rate and the 15-day stay maximum paid out of CalOptima funds with a 50/50 cost split arrangement with the County for stays of up to 90 days for homeless CalOptima members referred for medically justified recuperative care services under OCHCA's Whole Person Care Pilot program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the grant agreement with the County of Orange to include indemnity language and allow for use of the above allocated funds for recuperative care services under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members.

Background
Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus, funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:
- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the board approved priority areas. The RFI/LOIs helped staff determine funding allocation amounts for the board-approved priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

Priority Area	# of LOIs
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

Staff examined the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

In May 2017, CalOptima received final payment from DHCS for the IGT 6 and 7 transaction and confirmed CalOptima's total share to be approximately $31.1 million.

Discussion

The IGT Ad Hoc committee consisting of Supervisor Do and Directors Nguyen and Schoeffel met on February 17 and reconvened on April 17 to further discuss the results of the RFI/LOI responses specifically in the Homeless Health priority area and to review the staff-recommended IGT 6 and 7 expenditure plan with suggested allocation of funds per priority area.

Since receiving the RFI/LOIs, the County of Orange over the past several months has been engaged in addressing the homelessness in Orange County. Numerous public agencies and non-profit organizations, including CalOptima, have been working diligently to address this challenging matter. A lot has been accomplished, yet much more needs to be addressed.

Before making recommendation to the Board on the release of the limited grant dollars, the Ad Hoc committee met to carefully review the staff-recommended IGT 6 and 7 expenditure plan while also considering the pressing homeless issue.

In response to this on-going and challenging environment, and through the recommendation of the Ad Hoc committee, staff is recommending an allocation of up to $10 million to the OCHCA from IGT 6 and 7 to address the health needs of CalOptima's members in the priority area of Homeless Health

This will result in a remaining balance of approximately $21.1 million, which the Ad Hoc will consider separately and return to the Board with further recommendations.

In addition, staff is seeking authority to amend the grant agreement with the County to direct the allocation of up to $10 million of funds to provide recuperative care services for homeless CalOptima members under the recuperative care/WPC Pilot. The current agreement with the County allows CalOptima to pay for a maximum of $150 per day up to 15 days of recuperative care per member, with the County responsible for any costs. Staff is proposing to remove the cap on the daily rate and allow the $10 million to be used for funding 50 percent of all medically justified recuperative care days up to

a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available, and subject to negotiation of an amendment to include indemnification by the County in the event that such use of CalOptima IGT funds is subsequently challenged or disallowed.

The WPC Pilot, a county-run program is intended to focus on improving outcomes for participants, developing infrastructure and integrating systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. The current WPC Pilot budget and services are as follows:

		Add'l	
	Total WPC	**County Funds**	**CalOptima**
WPC Connect - electronic data sharing system	$ 2,421,250	$ -	$ -
Hospitals - Homeless Navigators	$ 5,164,000	$ -	$ -
Community Clinics - Homeless Navigators	$ 7,495,000	$ -	$ -
Community Referral Network - social services referral system	$ 1,000,000	$ -	$ -
Recuperative Care Beds	$ 4,277,615	$ 3,483,627	$ 522,100
MSN Nurse - Review & Approval of Recup. Care	$ 628,360	$ -	$ -
211 OC - training and housing coordination	$ 526,600	$ -	$ -
CalOptima - Homeless Personal Care Coordinators & Data Reporting	$ 809,200	$ -	$ -
Housing Navigators	$ 1,824,102	$ -	$ -
Housing Peer Mentors	$ 1,600,000	$ -	$ -
County Behavioral Health Services Outreach Staff	$ 1,668,013	$ -	$ -
Shelters	$ 2,446,580	$ -	$ -
County Admin	$ 1,206,140	$ -	$ -
TOTAL	$31,066,860	$ 3,483,627	$ 522,100

Since the 2016, the OCHCA collaborated with other community-based organizations, community clinics, hospitals, county agencies and CalOptima and others to design the program and has met with stakeholders on a weekly basis. The recuperative care element of the WPC pilot is a critical component of the program. During the first program year, the WPC recuperative care program provided vital services to homeless CalOptima members. CalOptima members in the WPC pilot program are recuperating from various conditions such as cancer, back surgery, and medication assistance and care for frail elderly members. The WPC pilot program has three recuperative care providers providing services, Mom's Retreat, Destiny La Palma Royale and Illumination Foundation.

From July 1, 2017 through June 30, 2018, the WPC pilot program provided the following recuperative care services and linkages for members:

- 445 Homeless CalOptima members admitted into recuperative care for a total of 16,508 bed days
- 22% Homeless CalOptima members served by Illumination Foundation placed into Permanent Supportive Housing
- 4 Homeless CalOptima members in recuperative care approved for Long-Term Care services
- 6 Homeless CalOptima members in recuperative care approved for Assisted Living Waiver services

- Total cost for recuperative care services over the fiscal year: $2,946,700
    - Average length of stay: 37 days
    - Average cost per member: $6,623

The OCHCA experienced a shortfall in the budgeted funds for the WPC/Recuperative Care Program in Year 1 as more individuals were identified to be eligible for the program than projected. The Whole Person Care pilot budget is approximately $31 million, with $8.4 million allocated to provide recuperative care. As the WPC pilot moves into the new fiscal year, the program continues to experience a shortfall. To address the budget shortfall, the number of admissions into the recuperative care program was restricted; however, projected need is projected to increase over the next three years to approximately 2,368 homeless individuals, or 790 per year. The program will need approximately $18.6M over the next three years to meet the increased need for recuperative care services. The County's remaining WPC budget for recuperative care services over this period is approximately $5.3 million.

Individuals who are recovering safely through the program are connected to medical care, including primary care medical homes and medical specialists. In addition, members may receive behavioral health therapy and/or substance use disorder counseling services. Clients from the WPC pilot program are seven times more likely to use the Emergency Room (ER) and nine times more likely to be hospitalized than general Medi-Cal Members.

The WPC recuperative care program serves and is available for homeless CalOptima members when medically indicated, for members who are discharged from hospitals and skilled nursing facilities, as well as those referred from clinics, and OCHCA public health nurses.

Fiscal Impact
The recommended action to approve the allocation of $10 million from IGT 6 and IGT 7 to the OCHCA has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

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

Background

Intergovernmental Transfers are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the above referenced priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

Priority Area	**# of LOIs**
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

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Staff performed an examination of all the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

In late May 2018, CalOptima received final IGT 6 and 7 funding from DHCS, resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. IGT 6/7 funds totaled $31.1 million rather than the initially projected $22 million due to an adjustment in the enrollment numbers estimated by the California Department of Health Care Services and the higher federal match for the expansion population. On August 2, 2018, CalOptima's Board of Directors approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program; resulting in a remaining available balance of $21.1 million.

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do, and Directors Nguyen and Schoeffel, met on July 20 and July 27 to discuss the results of the 117 RFI/LOI responses for the Children's Mental Health, Opioid and other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the staff evaluation process and RFP recommendations, the Ad Hoc committee and staff determined allocation amounts and descriptions for each of the proposed six (6) Request for Proposals (RFPs). In addition, staff is recommending an allocation of IGT dollars for internal projects and program administration in the amounts indicated.

The Ad Hoc committee is recommending the following allocation of approximately $17.7 million for IGT 6 and 7 Board-approved priority areas through six (6) RFPs. Please note that multiple applicants may be selected per RFP to receive a grant award.

Community Grants

Request for Proposal	Priority Area	Allocation Amount
Access to Outpatient Mental Health Services	Children's Mental Health	~~$2,700,000~~ $4,850,000
Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	~~$7,000,000~~ $4,850,000
Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000

Rev. 9/6/18

Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$500,000
Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$1,000,000
Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA/Older Adult Health	$500,000
TOTAL		**$17,700,000**

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Internal Projects and Program Administration

In addition, staff is also recommending an allocation of approximately $3.4 million for internal projects and IGT program administration to manage all IGT program projects as follows:

Internal Project Examples: - IS and other infrastructure projects	$2,500,000
IGT Program Administration - Support for two (2) existing staff positions for three years - Grant Management System license, and other administrative costs for three years	$949,289 *(Approx. $317,000 per year for three years)*
TOTAL	**$3,449,289**

Staff anticipates returning with recommendations of RFP grantee awards and internal project(s) for Board approval following the completion of the community grant and internal project RFP application processes at the February 2019 Board meeting. The staff positions are Manager, Strategic Development, and Program Assistant, and the above proposed funding is in addition to $10 million allocated from IGT 6/7 for Homeless Health on August 2, 2018.

Fiscal Impact

The recommended action to approve the expenditure plan and allocation of $21.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT 6 & 7 Expenditure Plan Allocation

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

8/29/2018 — **Date**

IGT 6 & 7 Expenditure Plan Allocation

Board of Directors Meeting

September 6, 2018

Cheryl Meronk

Director, Strategic Development

IGT 6 & 7 - Background

- Board Established 3 New Priority Areas
  1. **Homeless Health**
  2. **Opioid and Other Substance Overuse**
  3. **Children's Mental Health**
  - ➢ Community needs identified by MHNA
  - ➢ Internal projects and IGT program administration
- Received 117 LOIs
- $10.0M allocated for County HCA for Homeless Health/WPC Recuperative Care
- Ad Hoc met to discuss recommendations for other categories

IGT 6 & 7 Funding

- **$31.1M** CalOptima's share
- **$10.0M** to County HCA for WPC Recuperative Care
- **$21.1M** remaining for recommended distribution
  - ➢ $17.7M for Community Grants
    - Six Request for Proposals (RFPs)
      - 2 RFPs in Children's Mental Health
      - 1 RFP in Opioid and other Substance Overuse
      - 3 RFPs for MHNA identified needs
  - ➢ $3.4M for Internal Projects and Program Administration

IGT 6 & 7 LOI Summary

Priority Area	# Received
Children's Mental Health	57
Homeless Health	36
Opioid & Other Substance Overuse	22
Other/multiple categories	2
Total	**117**

Children's Mental Health – 2 RFPs

RFP #	RFP Description	Funding Amount
1	Expand Access to Outpatient Mental Health Services	$2.7 million
2	Integrate Mental Health Services into Primary Care Settings	$7.0 million
	Total	**$9.7 million**

* Multiple awardees may be selected per RFP

RFP 1

Expand Access to Outpatient Children's Mental Health Services

- **Funding Amount:** $2,700,000
- **Description:**
  - Access to outpatient services
    - Create/expand school or resource center-based mental health services for children.
    - Provide services on-site, in-home, and/or afternoon/evening
    - Use an integrated model with community health workers to target vulnerable populations such as children experiencing homelessness, who have experienced traumatic incidences, homeless etc.
    - Provide additional support services to help promote stability and success

RFP 2

Integrate Children's Mental Health Services into Primary Care Settings

- **Funding Amount:** $7 million
- **Description:**
  - Integrate mental health services provided in primary care settings
    - Include behavioral health providers in clinics and/or other settings where children are provided health care services
    - Provide culturally sensitive services
    - Provide efficient and immediate access to mental health consultation
    - Provide health navigation/scheduling coordinator to ensure availability and follow-up of services

Opioid & Other Substance Overuse – 1 RFP

RFP #	RFP Description	Funding Amount
3	Increase access to Medication-Assisted Treatment	$6.0 million
	Total	**$6.0 million**

*Multiple awardees may be selected per RFP

RFP 3

Increase access to Medication-Assisted Treatment

Funding Amount: $6.0 million

- **Description:**
  - Increase access to Medication-Assisted Treatment (MAT) Programs
    - Combine behavioral and physical health services
    - Manage oversight and prescribing of FDA-approved medications and program administration
    - Provide management of patients' overall care coordination
  - Integrate pain management services
  - Ensure availability of providers/staff to deliver appropriate services
  - Establish a partnership with the Orange County Health Care Agency Drug Medi-Cal Organized Delivery System (ODS) for referrals/collaboration

Community Needs Identified by MHNA: Food Access – 3 RFPs

RFP #	RFP Description	Funding Amount
4	Expand Mobile Food Distribution Services	$500K
5	Expand Access and Food Distribution focused on Children and Families	$1 million
6	Expand Access to Older Adults Meal Programs	$500K
	Total	**$2 million**

*Multiple awardees may be selected per RFP

RFP 4

Expand Mobile Food Distribution Services

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase availability and access to healthy food options in areas of where fresh food/grocery stores are limited
  - Ensure additional mobile food trucks/vehicles to distribute healthy food options such as fresh produce/groceries that are culturally appropriate in areas of greatest need
  - Enroll members in mobile food distribution services programs
  - Provide education to prepare nutritious meals and/or pre-made meal options and simple recipes

RFP 5

Expand Access and Food Distribution Services focused on Children and Families

- **Funding Amount:** $1 million
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Access to healthy food options such as fresh fruits, vegetables and other groceries
  - Increase access to culturally appropriate food options
  - Enroll/connect members to food distribution service programs
  - Provide education and simple recipes to help families on a limited budget
  - Provide take-home meals for children/families who may not have access to cooking facilities

RFP 6

Expand Access to Older Adult Meal Programs

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase access to:
    - Healthy options such as fresh fruits, vegetables and other groceries in areas of highest need
    - Culturally appropriate food options
    - Home delivered meals
  - Enroll/connect member food distribution service programs

Internal Projects/Program Admin.

Description	Amount
IS and Other Infrastructure Projects	$2.5 million
Support for staff and administrative costs	~$315K/year (for 3 years)

Next Steps*

- IGT 6 & 7 RFP Recommendations: September 6, 2018 Board Meeting
- Release of RFPs: September 2018
- RFPs due: November 2018
- IGT Ad Hoc review of recommended grant awards: January 2019
- Recommended awards: February 2019 Board Meeting

* Dates are subject to change based on Board approval

Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

Current System of Care

Key Roles	Agency
Public Health	County
Physical Health	CalOptima*
Mental Health – mild to moderate	CalOptima*
Serious Mental Illness (SMI) and Substance Use Disorder	County
Shelters	County and Cities
Housing supportive services for SMI population • Housing search support • Facilitation of housing application and/or lease • Move-in assistance • Tenancy sustainment/wellness checks	County
Intensive Care Management Services	County and CalOptima*
Medi-Cal Eligibility Determination and Enrollment	County
Presumptive Medi-Cal Eligibility	State Medi-Cal Fee-for-Service Program

**For Medi-Cal Members*

Current System of Care (Cont.)

- Services available to Medi-Cal members through CalOptima
  - Physician services – primary and specialty care
  - Hospital services and tertiary care
  - Palliative care and hospice
  - Pharmacy
  - Behavioral health (mild to moderate)
- Recuperative care funding with IGT dollars through County's Whole-Person Care Pilot
  - A clean and safe place for homeless individuals to recover from illness or injury for up to 90 days
  - A form of short-term shelter based on medical necessity

Gaps in the Current System of Care

- Access issues for homeless individuals
  - Difficulty with scheduled appointments
  - Challenges with transportation to medical services
- Coordination of physical health, mental health, substance use disorder treatment, and housing
- Physical health for non-CalOptima members who are homeless
  - Individuals may qualify for Medi-Cal but are not enrolled

Immediate Response

- In 2018, more than 200 reported homeless deaths in Orange County
  - Roughly double the number of homeless deaths in San Diego County
- CalOptima Board
  - On February 20, 2019, Quality Assurance Committee tasked staff to investigate
    - Percentage that were CalOptima members
    - Demographics
    - Causes of death
    - Prior access to medical care
  - Identify opportunities for improvement

Strengthened System of Care

- Vision
  - Deliver physical health care services to homeless individuals where they are
- Partner with FQHCs to deploy mobile clinical field teams
  - Reasons for partnering with FQHCs
    - Receive CalOptima reimbursement for Medi-Cal members
    - Receive federal funding for uninsured
    - Enrollment assistance into Medi-Cal
    - Offer members education on choosing FQHC as their PCP
  - About the FQHC clinical field teams (a.k.a., “Street Medicine”)
    - Small teams (e.g., physician/NP/PA, medical assistants, social worker)
    - Available with extended hours
    - Go to parks, riverbeds and shelters
    - In coordination with County Outreach and Engagement Team (a.k.a., “Blue Shirts”)

Federal and State Guidance

- Depending on the state-specific waivers and county contracts with state, Medicaid funds can be used for coverage of certain housing-related activities, such as
  - Intensive case management services
    - Section 1915(c) Home and Community Based Services waiver
      - e.g., In-Home Supportive Services and Multipurpose Senior Services Program
  - Housing navigation and supports
    - Section 1115 waiver
      - e.g., Whole-Person Care Pilot

Federal and State Guidance (Cont.)

- Medicaid funds cannot be used for rent or room and board
  - CMS Informational Bulletin – June 26, 2015
- CalOptima's Medi-Cal revenue and reserves can be used for the CalOptima Medi-Cal program only
  - Welfare & Institutions Code section 14087.54 (CalOptima enabling statute)

Activities in Other Counties

- Los Angeles County
  - LA County administers a flexible housing subsidy pool
  - L.A. Care provided a $4 million grant (total commitment of $20 million over 5 years) for rent subsidies to house 300 individuals
    - L.A. Care has other sources of revenue beyond Medi-Cal (e.g., Covered California commercial plan)
- Riverside and San Bernardino Counties
  - Inland Empire Health Plan contributes to a housing pool to provide housing supportive services for 350 members
- Orange County
  - Housing pool not in existence today under WPC Pilot
  - If established pursuant to the 1115 Waiver (e.g., under WPC), CalOptima could contribute funds for housing supportive services, not rent

Considerations

- Establish CalOptima Homeless Response Team
  - Dedicated CalOptima resources
  - Coordinate with clinical field teams
  - Interact with Blue Shirts, health networks, providers, etc.
  - Work in the community
  - Provide access on call during extended hours
- Fund start-up costs for clinical care provided to CalOptima members
  - On-site in shelters
  - On the streets through clinical field teams

Additional Considerations

- Look at opportunities to support CalOptima members who are homeless
  - ➢ Contribute to a housing pool
    - Housing pool must exist under an 1115 waiver program (e.g. WPC) in order to use Medi-Cal funds
    - CalOptima contribution used towards housing navigation and support services; cannot be used towards rent or room and board

Recommended Actions

- Authorize establishment of a clinical field team pilot program
  - Contract with any willing FQHC that meets qualifications
  - ~~CalOptima financially responsible for services regardless of health network eligibility~~
  - ~~One year pilot program~~
  - ~~Fee-for-service reimbursement based on CalOptima Medi-Cal fee schedule~~
- Authorize reallocation of up to $1.6 million from IGT 1 and 6/7 to fund start-up costs for clinical field team pilot
  - ~~Vehicle, equipment and supplies~~
  - ~~Staffing~~

Recommended Actions (Cont.)

- Authorize establishment of the CalOptima Homeless Response Team
  - Authorize eight unbudgeted FTE positions and related costs in an amount not to exceed $1.2 million
- Return to the Board with a ratification request for further implementing details
- Consider other options to work with the County on a System of Care
- Obtain legal opinion related to using Medi-Cal funding for housing-related activities

CalOptima's Mission

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


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

RFP 1. Expand Access to Outpatient Children's Mental Health Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Access California Services	$ 195,000	Playing with Rainbows	Provide an innovative play-based therapeutic program that facilitates the process of healing in immigrant and/or refugee children who have been traumatized by war and migration through the use of a group counseling process involving play and art.
Boys & Girls Club of Anaheim Inc.	$ 1,331,418	Wild at Heart	A therapeutic wilderness program focused on improving children's mental health, coping skills and resilience through evidence-based outdoor experiential therapy to at-risk youth aged 12 to 18
Boys & Girls Clubs of Garden Grove	$ 325,200	Teen Mental Health Leadership Program	Reduce stigma, increase coping skills, and triage mental health care by providing peer training to community-based teen empowerment programs and education around outreach and stigma reduction.
Casa de la Familia (CDLF)	$ 1,840,968	SAUSD Mental Health Project	Provide culturally sensitive counseling, case management, outreach and parental support services to students and parents within the Santa Ana Unified School District.
Child Guidance Center, Inc	$ 1,207,053	School Based Behavioral Health Services for Military/Veteran Connected Families	Expand resource center-based behavioral health services for veteran and military connected children by providing early intervention, prevention programs and behavioral health services to children in a community-based setting. Program will also provide training to schools and implement peer navigators. Program will leverage MHSA Innovation project with the Family Resource Centers.

Organization Name	Request ($)	Project Title	Project Description
Children's Bureau of Southern California (Children's Bureau)	$ 3,500,000	Children's Mental Health Access Collaborative	Bring together 12 outpatient mental health services providers to expand access to mental health services and increase coordination, outreach, peer support, and systems integration. Providing other Early Childhood Mental Health interventions not currently covered by MHSA funds or Medi-Cal.
CSU Fullerton Auxiliary Services Corporation	$ 4,033,395	The Early Childhood Mental Health and Wellness Program	Implement a Early Childhood Mental Health and Wellness Program through a facilitated process by a consultant and a leadership team of early care and education programs.
Gay and Lesbian Community Services Center of Orange County	$ 120,000	LGBT Center OC's Mental Health Program for Children and Youth	Provide CalOptima members ages 4-18 years with individual and family therapy as appropriate; mental health support groups for children and youth; drop-in counseling sessions for foster children; and; community groups focused on mental and emotional wellness
Hurtt Family Health Clinic	$ 745,812	Family Counseling Services for Homeless, Poor and Foster Children and Youth	Provide family counseling services to homeless families residing in Orange County Rescue Mission's transitional housing programs.
Illumination Foundation	$ 1,080,384	Children and Family In-Home Stabilization Program	Bring in-home services and individualized counseling to more families with children who are at risk of developing emotional and behavioral disorders.
Jamboree Housing Corporation	$ 692,000	Children's Behavioral Health Peer Navigation Collaboration	Pilot program to provide accessible behavioral health services for children and their families living at Jamboree's Clark Commons and surrounding Buena Park communities through an afterschool program, resident leadership training, food and nutrition workshops, and computer classes. The program will use an evidence-based peer navigation model (peer with lived experience), as well as connect members to clinical care.

Organization Name	Request ($)	Project Title	Project Description
Latino Center for Prevention & Action in Health & Welfare DBA Latino Health Access for Children with Adverse Childhood Experiences	$ 450,000	Promotora/ Community Health Worker-Facilitated Emotional Wellness and Mental Health Services	Prevention and intervention mental health program for Latino children who have had Adverse Childhood Experiences (ACE) that have resulted in trauma.
Living Success Center, Inc.	$ 1,351,000	Outreach and Education Expansion of Children's Mental Health Services	A 3-year outreach and education project to identify those in need, targeting homeless shelters and domestic violence service providers to help and counsel children who have experienced trauma .
Mariposa Women and Family Center	$ 238,898	Mariposa Children's Intervention Program (CHIP)	Use existing partnerships with local school districts, local community institutions, and low-income parents to provide programming to engage children and identify and treat mental health issues among children in Orange County.
NAMI Orange County	$ 546,380	Mental Health Education & Outreach	Offer evidence based programs such as Parent Connector, Basics Education, Progression, NAMI Connects at CHOC, and a quarterly Family Fun Event - 1K Awareness Walks for Families in collaboration with Family Resource Centers (FRC).
OC United	$ 901,500	Creating Capacity and Expanding Resilience for Children, Families, and their Communities	Expand current program engagement in local organizations, pilot a Whole-Child Treatment Team model, increase community resilience and engagement, reduce stigma, as well as increase accessibility to resources.
OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$ 685,000	The API Project HOPE	Provide mental health and wellness, culturally competent and linguistically appropriate services that include outreach and education to promote health awareness, support groups, educational trainings, resource referral and linkage, etc. Program will provide case management, in-home/community-based group counseling.

Organization Name	Request ($)	Project Title	Project Description
Orange County Department of Education	$ 4,583,290	School-Based Student Wellness Centers	Pilot School-Based Student Wellness Centers (SWCs) within seven Orange County districts where all students can access support, resources and information on a variety of topics around mental health at their school site.
PADRES UNIDOS	$ 55,000	Early Learning Programs	Provide community-based modules such as Parents as Teachers/Early Education Modules where parents have identified that preschool-aged kids exhibit early signs of concerning behavior that can lead to future mental health challenges.
Radiant Health Centers	$ 450,000	Children's Mental Health Program Expansion	Provide outreach, community partnership building and outpatient mental health services with a focus on the subpopulations of children infected or affected by HIV and LGBTQ+ youth. The program will reduce stigma, increase awareness of mental health services and increase access to services.
Straight Talk Clinic, Inc.	$ 186,000	Children's Mental Health Support	Expand program with a pilot weekly on-site counseling services and comprehensive outreach series for children and families.
The Center for Autism & Neurodevelopmental Disorders	$ 743,672	Child Mental Health Cooperative (CMHC)	Expand child mental health services by delivering a consultative support program to providers, creating a unique interactive video-conferencing classroom and optimizing partnerships and collaborations.

Organization Name	Request ($)	Project Title	Project Description
Vision y Compromiso	$ 875,235	Salud y Bienestar Para Todos	Collaborate with schools and community partners in Anaheim and Westminster to deliver evidence-based outreach and education strategies by engaging *promotores* to share information and resources.
Vista Community Clinic	$ 433,045	Providing School-Based Mental Health Services to La Habra Youth in Need	Project will designate 3-5 schools in La Habra as interim FQHC sites and assign three Licensed Clinical Social Workers to provide on-campus, 1-on-1 therapy to youth with mild to moderate behavioral health symptoms.
Wellness & Prevention Center	$ 153,951	Expansion of School and Community-based Youth Wellness Programming	Increase bilingual staff, support a coalition of Spanish-speaking parents and providers, and establish a presence at five new schools and community centers.
Women's Transitional Living Center, Inc.	$ 50,000	Children's Therapy Program	Counselors work with children through treatment plans that are age-appropriate, creative, and flexible, and can incorporate a range of counseling services, including individual counseling, family counseling, art therapy, sand therapy, and play therapy.

RFP 2. Integrate Children's Mental Health Services Into Primary Care			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
AltaMed Health Services Corporation	$ 998,040	Integrating Children's Mental Health Into Primary Care in Orange County	Enhance current pediatric primary care services by integrating mental health services for children, providing referrals to early intervention, and engaging parents through community outreach and education.
CHOC Children's	$ 4,785,076	Expanding Mental Health Access and Knowledge in Pediatric Primary Care and Community Settings	Establish mental health screening, embedded mental health services, telehealth, and resource and referral for members in clinics served by CHOC Medical Group and in CHOC's Primary Care Network. Program will also provide trainings over the 3 years.
Families Together of Orange County	$ 920,000	Expanding Children's Mental Health Services	Integrate children's mental health services into primary care by offering on-site outpatient pediatric mental health care at the community health center in Tustin with outreach and education.
Friends of Family Health Center	$ 600,000	Healthy Steps	Introduce the evidence-based model HealthySteps program designed to have a specialist screen and provide families with support for common and complex concerns during a well-child visit. The HealthySteps specialist will assist with referrals and connects to additional services.
Laguna Beach Community Clinic	$ 69,109	Pediatric Mental Health: Screening and Case Management to Increase Access to Treatment	Provide screening, case management, and linkage to mental health resources and treatment for Cal-Optima members
Livingstone Community Development Corporation	$ 626,000	Integrating Children's Mental Health Services into Medical Care	Integrate outpatient mental health services into pediatric primary care screening and expand its arts and music therapy program.
Share Our Selves Corporation (SOS)	$ 200,000	Children's Mental Health Expansion Project	Expand SOS Children and Family Health Center's hours of operation from 40 to 45 hours per week and access to behavioral health outreach education and counseling services.

IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 2,848,235	Child Psychiatry Consultation and Fellowship Program for Primary Care Providers (CPCFP)	Provide same day telephone consultation to PCPs by a child and adolescent psychiatrist in addition to rapid tele-video consult with ongoing education and training in mental health.
The Safety Net Foundation (FQHC Collaborative)	$ 2,496,000	Pediatric Integration of Behavioral Health in Primary Care for CalOptima's Safety Net: Expansion of Care Coordination, Mid-Level Provider Availability, Telehealth Options and Evidence-Based Training at Community Health Centers	Increase access to pediatric mental health care through the expansion of mid-level providers, the exploration of telemedicine and the integration of behavioral health with pediatric primary care.
Vista Community Clinic	$ 426,422	Enhancing Children's Mental Health via Primary Care Integration and Community Outreach in La Habra	A primary care - mental health integration project for Hispanic youth and their families living in and around the City of La Habra.

IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

RFP 3. Increase Access to Medication-Assisted Treatment			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Ahura Healthcare	$ 2,850,000	Medicated-Assisted Treatment (MAT)	Provide comprehensive mental health and addiction medicine care with the use of Medicated-Assisted Treatment (MAT) therapy such as Suboxone, Methadone, and Naltrexone provided by licensed physicians along with mental health services and counseling.
Bright Heart Health	$ 3,915,000	Opioid Use Disorder OnDemand Treatment	Provide complete telehealth MAT services through Data2000 physicians, nurse practitioners, and physician assistants.
Central City Community Health Center	$ 930,000	CCCHC SUD-MAT Services & Educational Program	Expand access to and enhance existing, integrated and evidenced-based, SUD-MAT clinical care program with the City of Anaheim Health Center as the "hub" with services available via in-person provider or telehealth. The project includes providing service through mobile units.
Clean Path Recovery LLC	$ 5,998,484	Clean Path Recovery MAT Program	Program will use FDA approved medications in combination with counseling, holistic and behavioral therapies.

IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
Coalition of Orange County Community Health Centers	$ 5,998,000	MATCONNECT: A County-wide Collaborative for MAT Expansion to CalOptima Members at Community Health Centers	Build capacity and expand access and delivery of MAT services by bridging integration gaps in the Substance Use Disorder (SUD) system of care in Orange County. Implement a localized version of the DHCS Hub and Spoke model and build internal capacity for increased MAT services and access for each of the Spoke locations.
Friends of Family Health Center	$ 600,000	Medication Assisted Treatment	Introduce Medication Assisted Treatment (MAT) with emphasis on opioid addiction with an individually tailored and extensive care coordination for patients
Livingstone Community Development Corporation	$ 808,000	Establishing a Substance Abuse Program with Medication-Assisted Treatment	Establish a new medication-assisted treatment (MAT) program which will be integrated with physical and behavioral health services and include supervised exercise and acupuncture treatments.
Serve the People	$ 1,485,000	Integrated Behavioral Health for Hard To Reach Populations	Purchase and staff Integrated Services (IS) Mobile Clinics and provide integrated whole-person care to individuals at the Courtyard and to others in addiction treatment facilities.
Share Our Selves Corporation (SOS)	$ 200,000	SOS Behavioral Health Expansion Project	Increase capacity to provide comprehensive behavioral health and case management services via telehealth technology and new medical/behavioral health mobile unit at homeless shelters operated by SOS's partner agencies throughout the county.

Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 1,825,518	Establishing and Increasing the capacity of a Medication Assisted Treatment program through a Hub-and-Spoke model for CalOptima patients	Establish and expand the capacity of medication-assisted treatment (MAT) within Orange County. The hubs will be the Zephyr Medical Group in Laguna Hills and UC Irvine Medical Center.

RFP 4. Expand Mobile Food Distribution Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 250,000	OC Food Bank Mobile Food Trolley	Project will use OC Food Bank's mobile food trolley to provide a variety of food that is distributed on a first-come, first-served basis and may include items such as produce, non-perishable goods and protein.

RFP 5. Expand Access to Food Distribution Services Focused on Children and Families			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Global Operations & Development / Giving Children Hope	$ 50,000	We've Got Your Back (WGYB)	Food distribution program fills and distributes more than 1,100 backpacks of nutritious food including fruits and vegetables on a weekly basis.
LiveHealthy OC	$ 990,000	The LiveHeathy OC "Farmacy" Project - Establishing a Sustainable Farm to Clinic Network to Increase Access to Fresh, Healthy Foods for Underserved and Low Income Patients	Expands current access to fresh fruits and vegetables using a sustainable farm-to-clinic produce delivery system – the "farmacy" – at five community health centers through a monthly mobile farmers' market.
Livingstone Community Development Corporation	$ 300,000	Expanding Food Access for Children and Families	Expanding food pantry and integrate access to the food pantry into Group Medical Visits with CalOptima members suffering from diabetes, obesity, hypertension, and/or heart disease
Serve the People	$ 1,000,000	OC Food Oasis Partnership	Expand mobile food distribution to five FQHC sites and shelters that serve homeless persons. The strategy is to include healthy food and meal distribution, nutrition education, a 'food as medicine' prescription food box program for patients with chronic disease, and demonstrations on healthy food preparation and cooking, plus outreach and case management to services establishing a system to address social determinants of health.

Organization Name	Request ($)	Project Title	Project Description
Vista Community Clinic	$ 289,533	In the Kitchen: An Innovative Education/Food Distribution Program in La Habra	Develop a teaching kitchen that will provide nutrition education and hands-on cooking lessons to participants (accommodate groups of 12 residents).

RFP 6. Expand Access to Food Distribution Services for Older Adults			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 231,514	Farm-to Seniors Food Distribution Program	Provide fresh, healthy food to older adult CalOptima members through a network of 17 distribution sites.
Multi-Ethnic Collaborative of Community Agencies	$ 500,000	Increasing Food Access for Underserved Multi-Ethnic Older Adults	Expand food access distribution at the seven MECCA sites by building the volunteer base capacity, expand outreach, and provide culturally appropriate education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing Amendments to Medi-Cal Health Network Contracts Except Those Associated with AltaMed Health Services Corporation to Include Language for the Health Homes Program and Consider Ratifying Memorandum of Understanding with HCA Related to the Health Homes Program

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to:
   a. Amend the CalOptima Medi-Cal Health Network Contracts, except those associated with AltaMed Health Services Corporation, to provide Health Homes Program (HHP) services, including responsibilities as Community Based-Care Management Entities (CB-CMEs), as well as include all subcontracting requirements of the California Department of Health Care Services (DHCS);
   b. Amend the Business Associate Agreements, as necessary, for network data sharing; and
2. Ratify the Behavioral Health Memorandum of Understanding (MOU) amendment with the Orange County Health Care Agency to reflect coordination of services for CalOptima members with mental health conditions who enroll in the Health Homes Program, effective October 1, 2019.

Background/Discussion

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

HHP Eligible Members and HHP Enrollment

Members with certain chronic physical conditions, SUD and SMI and meeting specified medical condition acuity requirements may qualify to participate in HHP. In order to participate, members must actively choose to enroll into HHP. Based on DHCS eligibility criteria, CalOptima staff plans to actively outreach to Medi-Cal only members potentially eligible for HHP and actively engage these members through written, telephonic, and face-to-face encounters to encourage member participation in HHP. CalOptima anticipates that approximately 30,000 Medi-Cal only members will be potentially eligible for HHP and that approximately 10% -25% of these eligible members will elect to participate. HHP eligible members who are currently in Whole Person Care Pilot program can also elect to enroll in HHP, however services provided under both programs cannot be duplicated. CalOptima's dually eligible

members can be referred to participate in HHP by community providers if members meet HHP eligibility criteria.

HHP Network Delivery Model
In developing CalOptima's HHP strategy, staff has considered the impact of these new HHP requirements to CalOptima's current delivery system. The impact analysis has included reviewing staffing resources, process and system enhancements, data exchange, and available community resources for new HHP services, such as accompaniment to appointments, housing transition services and tenancy sustaining services. Many of the CB-CME responsibilities are currently being provided by CalOptima's health networks. For HHP, CalOptima can leverage existing infrastructure to incorporate the new HHP services.

HHP focuses on a small percentage of CalOptima's overall membership. Based on the member distribution of HHP enrollment projections within the health networks, CalOptima staff's initial recommended approach was to provide health networks with an option of participating in HHP; however, this approach would potentially have required members to change their health networks and/or primary care providers when enrolling in HHP. In January 2019, DHCS advised that CalOptima must adhere to HHP expectation of not requiring members to change their health networks and/or primary care providers in order to participate in the HHP. Consequently, CalOptima will require all health networks, including CalOptima Direct and CalOptima Community Network, to participate in HHP and meet CB-CME requirements. This approach will provide an adequate CB-CME network and ensure continuity of members' relationships with their respective health networks and primary care providers.

Health Network Contracts
In order to implement HHP, CalOptima health network contracts will need to be amended, effective January 1, 2020, to include providing HHP services, expectations of CB-CME responsibilities, guidelines for information and data sharing, as well as HHP training. Prior to implementing HHP, CalOptima will coordinate with the health networks regarding the development of infrastructure, policies and procedures, reporting capabilities, staffing ratio requirements, and the ability to deliver core services with added intensity and new select services, where appropriate.

Amendment to County Behavioral Health MOU
Pursuant to DHCS All Plan Letter 18-015: Memorandum of Understanding (MOU) Requirements for Medi-Cal Managed Care Plans, MCPs participating in HHP must coordinate care for members enrolled in HHP who also receive care through the Mental Health Plan (MHP or County). The MOU with the Orange County Health Care Agency is the vehicle for ensuring this coordination. The Behavioral Health MOU between CalOptima and the County of Orange has been amended to reflect that CalOptima and the County agree to coordinate appropriate services for CalOptima members with mental health conditions who are enrolled in HHP.

Implementation Efforts
Based on DHCS feedback and in partnership with the health networks, CalOptima staff continues to develop and adjust operational procedures and polices outlining HHP requirements and operational processes impacting member engagement and enrollment, care management, CB-CME network and its responsibilities, staffing requirements and MCP oversight role. Currently, CalOptima's policies impacted by HHP requirements have been submitted to DHCS as part of the HHP regulatory submission requirements. Once CalOptima receives the feedback from DHCS, CalOptima staff will return to the Board with recommendations for approval of policy and procedures impacted by HHP requirements.

Additionally, CalOptima staff will continue to collaborate with Orange County HCA, Health Networks, and other stakeholders for Phase II of the Health Homes Program for SUD, SMI, and homelessness consistent with requirements as specified by DHCS.

Fiscal Impact
The anticipated implementation date for HHP in Orange County is January 1, 2020. Management has included projected revenues and expenses for HHP in the CalOptima Fiscal Year 2019-20 Operating Budget and will for future operating budgets. Total actual revenue and expenses for HHP will depend on the number of members that choose to participate in the program. Based on projected enrollment and draft rates received from DHCS on April 2, 2018, CalOptima is projected to receive $26.3 million in funding for HHP over a three-year period.

Since this is a new program for CalOptima, there is the possibility that the rate development assumptions applied by DHCS may be materially different from CalOptima's actual utilization and expenses. Staff will closely monitor both utilization and expenses and will continue to work with DHCS to ensure that Medi-Cal revenue will be sufficient to support the program.

Rationale for Recommendation
The recommended actions will enable CalOptima to operationally prepare for the anticipated implementation of Health Homes Program, effective January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and SUD and July 1, 2020, for members with SMI.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program
3. Department of Health Care Services. Medi-Cal Health Homes Program, Program Guide 7/1/19
4. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Attachment to October 3, 2019 Board of Directors Meeting – Agenda Item 14

Health Network	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CalOptima Community Network	505 City Parkway West	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Ave, #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
Orange County Health Care Agency	405 W. 5th St.	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

Contact

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

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

Background

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

Discussion

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff's understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

	Requirement
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless. Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services. Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

	Requirement
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

Rationale for Recommendation

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014

A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 28, 2018

ALL PLAN LETTER 18-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

SUBJECT: HEALTH HOMES PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

BACKGROUND:
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

POLICY:
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

and guidelines. DHCS will notify MCPs whenever the Program Guide is updated, so that MCPs can obtain the latest information on HHP.

HHP MCPs must meet all program and reporting requirements specified in the Program Guide, all applicable state and federal laws and regulations, MCP contracts, and other DHCS guidance, including, but not limited to, APLs. Additionally, MCPs must communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including Community Based Care Management Entities, as well as any delegated entities and subcontractors.

MCPs are responsible for ensuring that all delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Medi-Cal Health Homes Program
Program Guide
7/01/19

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I. Introduction

The Medi-Cal Health Homes Program: Program Guide (Program Guide) is intended to be a resource for Medi-Cal Managed Care health plans (MCPs) in the development, implementation, and operation of the Health Homes Program (HHP). The Program Guide includes a brief synopsis of the HHP, identifies all HHP requirements, and identifies the documentation MCPs must submit to the Department of Health Care Services (DHCS) as part of the required HHP readiness review. The Program Guide refers to additional guidance documents, when applicable.

The Medicaid Health Home State Plan Option is afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Enhanced federal matching funds of 90% are available for two years.

In California, Assembly Bill 361 (AB 361) amended the Welfare and Institutions Code to add Sections 14127 and 14128 (W&I Code) which authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for members with chronic conditions. The W&I Code provides that the provisions will be implemented only if federal financial participation (FFP) is available and the program is cost neutral regarding State General Funds. It also requires DHCS to ensure that 1) an evaluation of the program is completed; and 2) a report is submitted to the appropriate policy and fiscal committees of the Legislature within two years after implementation of the program.

The Program Guide has five main sections (Infrastructure, Eligibility, Services, Network, and General Operations) and an appendix. Each section describes the program components and the requirements for those components.

The Program Guide contains the Health Homes Program: Medi-Cal Managed Care Plan Readiness Checklist (Readiness Checklist) in Appendix D. The Readiness Checklist identifies the specific components that MCPs are required to provide to DHCS and identifies the process DHCS will use to determine when the specific components are due to DHCS. The Program Guide provides additional guidance and context regarding HHP readiness requirements.

II. HHP Infrastructure

A. Organizational Model

DHCS' HHP implementation will utilize California's Medi-Cal Managed Care (Managed Care) infrastructure as the foundational building block. HHP services will be provided through the Managed Care delivery system to members enrolled in Managed Care. Managed Care serves approximately 85 percent of full scope Medi-Cal members and is an available choice for all full-scope Medi-Cal members statewide. The small percentage of Medi-Cal Fee-For-Service (FFS) members who meet HHP eligibility criteria may enroll in a Medi-Cal MCP to receive HHP services. HHP services will not be provided through the FFS delivery system.

The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP member to a primary care provider. The MCPs' existing communication and reporting capabilities will be utilized to perform health promotion, encounter reporting, and quality of care reporting. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHPs) in each county to facilitate HHP care coordination.

The HHP will be structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP). The HHP network will be developed to meet the following goals:

- Ensure that sufficient HHP funds are available to support care management at the point of care in the community
- Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available as needed
- Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
- Forge new relationships with community provider care management entities, where possible and appropriate
- Utilize community health workers in appropriate roles.

The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long Term Services and Supports (LTSS), oral health services, palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, ED visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between the MCP and the CB-CME, either through direct provision of HHP services,

or through contractual or non-contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

1) Medi-Cal Managed Care Plan Responsibilities

HHP MCPs will be responsible for the overall administration of the HHP. They will have an HHP addendum to an existing contract with DHCS. Payment will flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. The MCP may also use HHP funding to pay providers, including but not limited to, the member's primary care physician, behavioral health providers, or other specialists, who are not included formally on the CB-CME's multi-disciplinary care team, for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the Health Action Plan (HAP). These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).

The MCP will have strong oversight and will perform regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.

The MCP's care management department can be leveraged to train, support, and qualify CB-CMEs. (MCPs currently perform similar monitoring, training and auditing with MCP-delegated entities that have care management responsibilities under Cal MediConnect and other programs.)

MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow-up care. MCP health care informatics analytics teams will provide meaningful, actionable data with identification of complex members and care gaps and other pertinent data that the health plan network can access. This will be provided to the CB-CMEs to assist with HAP care planning and ongoing goals for the member.

Many MCPs are exploring housing options to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. Stakeholders include the health plan, hospitals, local housing authorities, and community-based organizations. Achieving stable housing for HHP members is a noted best practice from the national experience for achieving meaningful improvements in health and program cost effectiveness.

In counties selected for HHP implementation, Medi-Cal MCPs (Medicaid only benefit plans) are required to participate in HHP and serve as an HHP MCP. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness.

2) Duties

MCPs will be expected to perform the following duties/responsibilities to the extent their information systems allow or through other available methods:

- Attribute assigned HHP members to CB-CMEs;
- Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;

- Notify the CB-CMEs of inpatient admissions and ED visits/discharges;
- Track and share data with CB-CMEs regarding each member's health history;
- Track CMS-required quality measures and state-specific measures (see *Reporting Template* and *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,* or later *document*);
- Collect, analyze, and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process (see *Reporting Template*)
- Provide member resources (e.g. customer service, member grievances) relating to HHP
- Add functionality to the MCP's customer service line and 24/7 nurse line or other available call line so that members' HHP needs are also addressed (e.g. equip nurse line with educational materials to train them about HHP, nurse line receives the updated list of HHP members and their assigned care coordinator, etc.)
- Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and the CB-CME
- Establish and maintain a data-sharing agreement with other providers, with whom MCP shares HHP member health information, that is compliant with all federal and state laws and regulations
- Ensure access to timely services for HHP members, including seeing HHP members after discharge from an acute care stay.
- Encourage participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary care team, but who are responsible for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).
- Develop CB-CME training tools as needed or preferred, in addition to DHCS-provided training
- Develop CB-CME reporting capabilities
- Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

3) Community Based Care Management Entity Responsibilities

CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs through a process similar to current MCP provider certification and will contract with selected entities. DHCS will not require MCP use of a standardized assessment tool. DHCS will provide general guidelines

and requirements, including examples of best practice tools that the MCP can use at their option to select, qualify, and contract with CB-CMEs.

The MCP's development of a network of CB-CMEs should seek to promote HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient HHP funding are provided at the point of care in the community;
- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed per AB 361 requirements;
- Leveraging existing county and community provider care management infrastructure and experience, where possible and appropriate; and
- OPTIONAL - Utilizing community health workers in appropriate roles (for more information, see Multi-Disciplinary Care Team below).

CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. DHCS encourages MCPs and CB-CMEs to utilize this flexibility, where needed, to achieve HHP goals, and in particular the four network goals noted above.

In most cases, the CB-CME will be a community primary care provider (PCP) that serves a high volume of HHP eligible members. If the CB-CME is not the member's MCP-assigned PCP, then the MCP and the CB-CME must demonstrate how the CB-CME will maintain a strong and direct connection to the PCP and ensure the PCP's participation in HAP development and ongoing coordination. For all members, and in all areas, the MCP must demonstrate that it is maximizing the four network goals noted above to the full extent possible through its network development and HHP policies. Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP members will receive access to the same level of service, in accordance with the service tier that is appropriate for their needs and HHP service requirements.

DHCS' readiness review will include a detailed review of the MCP's HHP network. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide the full range of CB-CME duties, the MCP may perform needed CB-CME duties to fill a demonstrated service gap. As an alternative, the MCP may subcontract with other entities to perform these duties. In addition, the MCP may provide, or subcontract with another community-based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals. If the MCP utilizes this flexibility, the MCP must demonstrate to DHCS that it is maximizing the four network goals noted above to the

extent possible, and how it will maintain a strong and direct connection between HHP services and the primary care provider.

The MCP may allow an individual community provider to become a CB-CME after the implementation date of the HHP in their county if the community provider requires additional time to develop readiness to take on some, or all, of the CB-CME duties. The MCP may also allow a CB-CME to expand the range of the CB-CME's contracted CB-CME duties over time as readiness allows.

CB-CMEs that MCPs contract with to deliver HHP care coordination services are not required to be enrolled as Medi-Cal providers, so long as the entities in question are not providing medical and/or clinical services in their function as an HHP CB-CME to Medi-Cal members participating in the Program.

4) Community-Based Care Management Models

The main goal of the HHP is Comprehensive Care Management. The MCP, acting as administrator and providing oversight, will build an HHP network in which a member can choose the CB-CME they want for their care coordination. Given specific challenges in certain areas, including the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population, a single model is not practical. Assessments of potential HHP providers, and MCP knowledge of available resources in their areas, will form the basis for determining whether the provider's HHP-eligible members are best served by Model I, II, or III below.

The three community-based care management models below are acceptable for MCP network development and address the realities that exist in various areas of the state regarding available providers. The three models will allow the flexibility to ensure service to all HHP members throughout the diverse geographic regions in California, regardless of location and type of provider empanelment. Further, all three will allow increased care coordination to occur as close to the point of care delivery as possible in the community.

Model I

The first and ideal model embeds care coordinators on-site in community provider offices, acting as CB-CMEs. The expectation is that the community provider will employ these staff, but in some cases they may be employed by the MCP. This model will serve the great majority of HHP members because most HHP eligible individuals are served by high-volume providers in urban areas. The MCP will complete a provider assessment to determine 1) the extent to which the community provider will need to recruit and hire additional staff to meet the HHP care coordinator resource requirements, and 2) what CB-CME duties the community provider can, and is willing to, perform. The HHP will only utilize Model II or III where the provider assessment indicates that Model I is not viable.

Model II

The second model addresses the smaller subset of eligible members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site. For this model, the care management would be handled by another community-based entity or a staff member within

the existing MCP care management department, which will act as the CB-CME. This model will handle HHP members who are not assigned to a county clinic or medical practice under Model I.

Model III

The third model serves the few members who live in rural areas and are served by low-volume providers. In this hybrid model, care coordinators located in regional offices, utilizing technology and other monitoring and communication methods, such as visiting the member at their location, will become CB-CMEs who can be geographically close to rural members and/or those members who are assigned to a solo practitioner who may not have enough membership to meet Model I or II.

B. Staffing

1) Care Coordinator Ratio

The aggregate minimum care coordinator ratio requirement is 60:1 for the whole enrolled population (in each of the MCPs' counties if the MCP has more than one county) as measured at any point in time.

To develop the aggregate population care coordinator ratio requirement, DHCS assumed that (after two years):

- *Tier 1 – 20% of population; care coordinator ratio of 10:1*
- *Tier 2 – 30% of population; care coordinator ratio of 75:1*
- *Tier 3 – 50% of population; care coordinator ratio of 200:1*

2) Multi-Disciplinary Care Team

The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. DHCS requires the team members listed in Table 1 below to participate on all multi-disciplinary care teams. The team will primarily be located at the CB-CME organization, except as noted above regarding model flexibility. The MCP may organize its provider network for HHP services according to provider availability, capacity, and network efficiency, while maximizing the stated HHP goals and HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member's preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's physical and/or behavioral health service providers, for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's HAP. As an example, an MCP could use HHP care coordination funding to pay a member's specialist provider, who is not a contracted member of the CB-CME Multi-Disciplinary Care Team, for the time they spend participating in a case conference with the HHP care coordinator for the purpose of completing the member's HAP. The MCP may make such payments directly to the providers or through their CB-CME.

Table 1: Multi-Disciplinary Care Team Qualifications and Roles

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

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

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team. It is the responsibility of the MCP to ensure their cooperation.

C. Health Information Technology/Data

Health Information Technology (HIT)/Health Information Exchange (HIE) are important components of information sharing in the HHP.

MCPs should consider the following potential uses of HIT/HIE (developed by CMS) in the development of HHP information sharing policies and procedures for MCPs, CB-CMEs, and members:

1) Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management –standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement.
2) Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information.
   - Telehealth services including remote patient monitoring.
3) Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER.
   - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR.
   - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.
4) Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.
5) Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence).
   - Ability to electronically refer patients to necessary services.

Organizations that are covered by the Meaningful Use requirements should utilize EHR/HIT/HIE to meet the applicable goals noted above, where possible. Organizations that are not covered by Meaningful Use may need a Medi-Cal MCP to support the achievement of applicable goals where possible. In some areas relatively few providers have EHRs; there is limited interoperability between the systems; and, where there is an HIE in the area, the configuration may not be designed for the HHP requirements. If the technology environment does not fully support the EHR/HIT/HIE activities noted above in some geographic areas, or with certain providers, the MCP will determine procedures to share information that is critical for HHP services through other methods.

III. HHP Member Eligibility

A. Target Population

The HHP is intended to be an intensive set of services for a small subset of Medi-Cal members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of International Classification of Diseases (ICD)-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

B. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, DHCS will develop a Targeted Engagement List (TEL) of Medi-Cal MCP members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The TEL will be refreshed every six months using the most recent available data. The MCP will actively attempt to engage the members on the TEL. (See Member Assignment, for more information on MCP activity to engage eligible members.)

To be eligible for the HHP, a member must be full-scope, have no share of costs, and meet the following eligibility criteria. See Appendix B for *Targeted Engagement List data specification document* and specific ICD 10 codes that define these eligible conditions:

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in <u>at least one</u> of the following categories: • **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

The TEL may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal members who present the best opportunity for improved health outcomes through HHP services. The DHCS TEL is intended to be used by MCPs as a list of people who are likely to be eligible for the program based on the data available to DHCS; it is not, on its own, a comprehensive eligibility list.

Acuity Eligibility Criteria

Eligibility for HHP requires that members have the specified conditions and at least one of the four acuity criteria listed above. MCPs must have a process to verify eligibility as part of the enrollment process. MCPs can do this through reviews of the MCPs data and/or through other methods including discussion/assessment with the member or the member's providers. This additional verification is not only to confirm that the member meets eligibility, but also that they do not have exclusionary criteria such as enrollment in another duplicative care management program or being "well managed." For example, a member's qualifying utilization may have been for something unrelated to management of a chronic condition, such as maternity.

MCPs should make a preliminary eligibility determination based on their data prior to proceeding with proactive outreach and engagement. MCPs may rely on the TEL to verify that the member meets the eligibility criteria for having the eligible chronic conditions and the acuity criteria relating to having three or more of the eligible chronic conditions; however, the MCP should verify utilization acuity criteria (within 12 months) using the MCP's own data.

MCPs are required to review their own data for members who are on the TEL and should not proactively outreach members whose qualifying utilization is: 1) only found in the oldest four months of the TEL look-back period; and 2) unrelated to the HHP chronic conditions. MCPs may also apply their own additional prioritization policies upon approval from DHCS.

At the point in time when the MCP makes this data-driven preliminary eligibility determination, the member will be considered eligible for the program regardless of how long it takes the member to agree to enroll. The member may be enrolled for at least one month to complete the member assessment and care plan process. If additional information is determined during the assessment/care plan process that negates prior eligibility data or confirms an exclusionary criteria, then the member will be disenrolled.

Homeless Eligibility Criteria

Chronic homelessness for HHP is defined in W&I Code section 14127(e), and states *"a chronically homeless individual means a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years. For purposes of this article, an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing, as defined in Section 50675.14 of the Health and Safety Code, for less than two years shall be considered a chronically homeless individual if the individual was chronically homeless prior to his or her*

residence." For the purpose of verifying HHP acuity eligibility criteria, the portion of this definition which states "with a condition limiting his or her activities of daily living" is satisfied by verification that the member has one of the HHP-eligible conditions. No further assessment of activities of daily living limitation is required to establish that the member meets the portion of this eligibility acuity criterion underlined above. In addition, a member meets the HHP chronically homeless acuity eligibility criteria if the member meets either the W&I Code section 14127(e) definition or the Housing and Urban Development (HUD) definition.

People Excluded from Targeted Engagement List

The following exclusions will be applied either through MCP data analysis for individual members or through assessment information gathered by the Community-Based Care Management Entity (CB-CME) (see *Reporting Template-Instructions* for additional information):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program

IV. Health Home Program Services

This section describes the six HHP services. HHP arranges for and coordinates interventions that address the medical, social, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices available to HHP members.

All HHP engagement and services can be provided to members and family/support persons through e-mails, texts, social media, phone calls, letters, mailings, community outreach, and, to the extent and whenever possible, in-person meetings where the member lives, seeks care, or is accessible. Communication and information must meet health literacy standards and trauma-informed care standards and be culturally appropriate.

A. Comprehensive Care Management

Comprehensive care management involves activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, trauma-informed care, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and will be reassessed based on the member's progress or changes in their needs. It will also track referrals. The HAP must be completed within 90 days of HHP enrollment.

Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers.

Comprehensive care management services include, but are not limited to:

- Engaging the member in HHP and in their own care
- Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
- Promoting the member's self-management skills to increase their ability to engage with health and service providers
- Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
- Completing a comprehensive health risk assessment to identify the member's needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services
- Developing a member's HAP and revising it as appropriate
- Reassessing a member's health status, needs and goals
- Coordinating and collaborating with all involved parties to promote continuity and consistency of care
- Clarifying roles and responsibilities of the multi-disciplinary team, providers, member and family/support persons

1) Care Management Assessment Tools

To the extent possible and reasonable, DHCS will align new requirements for care management methods and tools with those currently used by MCPs for care coordination. MCPs have extensive experience administering Health Risk Assessments and developing care plans.

MCPs may use current Cal MediConnect or Seniors and Persons with Disabilities (SPD) care management tools, such as the Health Risk Assessment and Individualized Care Plan, as a base for developing health assessments and completing the HAP for HHP members. For the implementation of HHP, any assessment or planning elements that are required in the HHP and are not already included in an existing tool and/or process must be added to the existing MCP assessment and planning tools. Such elements could include an assessment of social determinants of health, including an indicator of housing instability, a need for palliative care, and trauma-informed care needs.

The HAP is defined as the Individualized Care Plan with the inclusion of any elements specific to HHP. When a member begins receiving HHP services, the member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed at regular intervals and when changes occur in the member's progress or status and health care needs.

The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care coordinators for all HHP members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities, the care coordinator will work with the HHP member and their family/support persons to develop a HAP.

2) Duties

MCPs in partnership with CB-CMES must be able to carry out the following comprehensive care management services:

Member Engagement and Support

a. MCPs must ensure that CB-CMEs accomplish the following:
    1) Engage the member in the HHP and their own care
    2) Assess the HHP member's readiness for self-management using standardized screenings and assessments with standardized tools
    3) Track and promote the member's self-management skills to increase their ability to engage with health and service providers
    4) Support the achievement of the member's self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines

Member Assessment

a. MCPs/CB-CMEs must have a process for assessing and reassessing the member to identify their needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services. The process should identify:
    1) How their tools align with current tools used for the defined population and avoid unnecessary duplication of assessment?
    2) How trauma-informed care best practices will be utilized?
    3) Whether the assessment process and HAP are standard across the CB-CMEs or whether variations exist.
b. MCPs/CB-CMEs must have a process and tools for developing the member's HAP and revising, as appropriate
c. MCPs/CB-CMEs must develop and use the HAP and screening and assessment tools, and develop processes for:
    1) How the HAP is shared with other providers and if it can be shared electronically; and
    2) How the HAP will track referrals and follow ups.

Coordination

a. MCPs/CB-CMEs must have a process for integrating community social supports, long term support services, mental health, substance use disorder services, palliative care, trauma-informed care, oral health, and housing services into a member's HAP
b. MCP must ensure that the CB-CMEs:
    1) Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and
    2) Clarify roles and responsibilities of the multi-disciplinary team, providers, HHP member, and family/support persons.
c. MCPs must have policies and procedures to ensure that members are not receiving the same services from another state care management program (see non-duplication of care coordination services for more information).

B. Care Coordination

Care coordination includes services to implement the HHP member's HAP. Care coordination services begin once the HAP is completed. HHP care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current

MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all service providers. All program staff who provide HHP services are required to complete CB-CME/care coordinator training as discussed in Appendix C.

Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

1) Member Support

- Working with the member to implement their HAP
- Assisting the member in navigating health, behavioral health, and social services systems, including housing
- Sharing options with the member for accessing care and providing information to the member regarding care planning
- Identifying barriers to the member's treatment and medication management adherence
- Monitoring and supporting treatment adherence (including medication management and reconciliation)
- Assisting in attainment of the member's goals as described in the HAP
- Encouraging the member's decision making and continued participation in HHP
- Accompanying members to appointments as needed

2) Coordination

- Monitoring referrals, coordination, and follow ups to ensure needed services and supports are offered and accessed
- Sharing information with all involved parties to monitor the member's conditions, health status, care planning, medications usages and side effects
- Creating and promoting linkages to other services and supports
- Helping facilitate communication and understanding between HHP members and healthcare providers

MCPs in partnership with CB-CMEs must develop, and ensure the implementation of, policies and procedures to support CB-CME coordination efforts to:

a. Maintain frequent, in-person contact between the member and the care coordinator when delivering HHP services. Minimum in-person visits for the aggregated population is 260 visits per 100 enrolled members per quarter. DHCS used the following assumptions to develop the aggregate population visit requirement listed above:
    i. After two years, the population equals: 20% in tier 1, 30% in tier 2, 50% in tier 3
    ii. Tier 1 – two in-person visits per month
    iii. Tier 2 – 1 in-person visit per month
    iv. Tier 3 – 1 in-person visit per quarter
b. Ensure members see their PCP within 60 days of enrollment in HHP. This is a recommended best practice only – not service requirement.
c. Ensure availability of support staff to complement the work of the Care Coordinator.
d. Ensure availability of providers with experience working with people who are chronically homeless.
e. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions.

f. Link eligible individuals who are homeless or experiencing housing instability to permanent housing, such as supportive housing.
g. Maintain an appointment reminder system for members. This is a recommended best practice only – not a service requirement.
h. Identify and take action to address member gaps in care through:
    i. Assessment of existing data sources for evidence of care appropriate to the member's age and underlying chronic conditions
    ii. Evaluation of member perception of gaps in care
    iii. Documentation of gaps in care in the member case file
    iv. Documentation of interventions in HAP and progress notes
    v. Findings from the member's response to interventions
    vi. Documentation of discussions of members care goals
    vii. Documentation of follow-up actions, and the person or organization responsible for follow-up

C. Health Promotion

Health promotion includes services to encourage and support HHP members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

Health promotion services include, but are not limited to:

- Encouraging and supporting health education for the member and family/support persons
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
- Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Linking the member to resources for: smoking cessation; management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care

D. Comprehensive Transitional Care

Comprehensive transitional care includes services to facilitate HHP members' transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, MCPs or CB-CMEs must provide information to hospital discharge planners about HHP.

Comprehensive transitional care services include, but are not limited to:

- Providing medication information and reconciliation
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
- Collaborating, communicating, and coordinating with all involved parties
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
- Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures
- Developing and facilitating the member's transition plan
- Preventing and tracking avoidable admissions and readmissions
- Evaluating the need to revise the member's HAP
- Providing transition support to permanent housing

E. Individual and Family Support Services

Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

Individual and family support services may include, but are not limited to:

- Assessing the strengths and needs of the member and family/support persons
- Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
- Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
- Accompanying the member to clinical appointments, when necessary
- Identifying barriers to improving the member's adherence to treatment and medication management
- Evaluating family/support persons' needs for services

F. Referral to Community and Social Supports

Referral to community and social support services involves determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources, and following up with the members.

Community and social support referral services may include, but are not limited to:

- Identifying the member's community and social support needs
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
- Providing member with information on relevant resources, based on the member's needs and interests.
- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
- Following up with the member to ensure needed services are obtained
- Coordinating services and follow-up post engagement
- Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
- Providing Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing
- Providing Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy

V. Health Homes Program Network

A. MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities:

a. Develop and implement criteria for network sufficiency determination, including county-wideness and number of projected members
b. Develop an adequate network of Community-Based Care Management Entities (CB-CMEs) in each of the MCP's implemented counties for HHP to serve enrolled members
c. Design and implement a process for determining the qualifications of organizations to meet CB-CME standards and for providing support for CB-CMEs, including:
    1. Identify organizations who meet the CB-CME standards
    2. Provide the infrastructure and tools necessary to support CB-CMEs in care coordination
    3. Gather and share HHP member-level information regarding health care utilization, gaps in care and medications
    4. Provide outcome tools and measurement protocols to assess CB-CME effectiveness
d. Integrate community entities focused on services to individuals experiencing homelessness into the care model and, if applicable, the multi-disciplinary care team; meet the State legislation requirement to ensure availability of providers with experience working with individuals who are chronically homeless.

e. Engage with community and social support services by building new, or enhance existing, relationships with programs, services, and support organizations to provide care to members, including but not limited to:
    1. County specialty mental health plans;
    2. Housing agencies and permanent housing providers; and
    3. Individual Housing and Tenancy Sustaining Services.
f. Contract with CB-CMEs for the provision of HHP services, including outlining the MCP and CB-CME roles and responsibilities, and ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, including the network development goals.
g. Have methods to ensure compliance with HHP requirements throughout the network, including portions of the network contracted through delegated entities.
h. Ensure the development of a communication and feedback strategy for all members of the HHP care team, including the member and their family/support persons, to ensure information sharing occurs. Encourage all of the HHP member's providers who supply input to the HAP and coordinate with the CB-CME care coordinator to conduct case conferences, including with those whom may not be formally included on the CB-CME's multi-disciplinary care team.
    1. If the CB-CME is not the member's MCP-assigned PCP, the MCP must have policies and procedures for ensuring: the MCP/CB-CME maintains a strong and direct connection to the PCP and PCP's participate in HAP development and ongoing coordination.
i. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

1) Administration

a. Attribute assigned HHP members to CB-CMEs, providing for increased care coordination as close to the member's usual point of care delivery as possible in the community. HHP members must be notified of their CB-CME options.
b. Receive payment from DHCS and disperse funds to CB-CMEs. Have policies and procedures regarding:
    1. The process for how an MCP determines that the appropriate level of services are provided and documented by CB-CMEs in accordance with the contract and service requirements; and
    2. The process/structure/tiering (if used) for payments to CB-CMEs.

2) Data Sharing and Reporting

a. Develop reporting capabilities and methodologies
b. Establish and maintain data-sharing agreements that are compliant with all federal and state laws and regulations, and when necessary, with other providers
c. Notify CB-CMEs of inpatient admissions and emergency department (ED) visits/discharges
d. Track and share data with CB-CMEs regarding each member's health history
e. Establish procedures for hospitals participating under the Medicaid State Plan or a waiver of such plan for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated HHP providers. However, HHP primarily uses the TEL to identify and refer members to HHP.

3) Training and Education

a. Develop and offer learning activities that will support CB-CMEs in effective delivery of HHP services
b. Develop CB-CME training tools, as needed, to supplement DHCS-developed tools.
c. Ensure participation of the CB-CME and MCP staff delivering HHP Services in DHCS-required CB-CME and care coordinator training and learning collaboratives.

B. CB-CME Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with W&I Code HHP requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed. If in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized, if culturally appropriate and accessible for the HHP member, to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by the MCP, according to the CB-CME contract with the MCP;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and MCP and other providers involved in the HHP member's care.

C. CB-CME Certification

Organizations must be one of the following types of organizations and be able to meet the qualifications above and perform the duties below to be authorized to serve as a CB-CME:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health center
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group

- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the MCP

D. CB-CME General Duties

CB-CMEs will be expected to perform the following duties/responsibilities:

- Be responsible for care team staffing, according to HHP required staffing ratios determined by DHCS, and oversight of direct delivery of the core HHP services;
- Implement systematic processes and protocols to ensure member access to the multi-disciplinary care team and overall care coordination;
- Ensure person-centered health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical physical and behavioral health care related needs and services, and social services needs and services;
- Collaborate with and engage HHP members in developing a HAP and reinforcing/implementing/reassessing it in order to accomplish stated goals;
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure that the HHP member care is integrated among providers;
- Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and to improve health;
- Provide evidence-based care;
- Monitor referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up;
- Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
- Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);
- Provide service in the community in which the HHP member lives so services can be provided in-person, as needed;
- Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP member; and
- Provide quality-driven, cost-effective HHP services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy.

VI. General HHP Operations

A. Non-Duplication of Care Coordination Services

MCPs must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving HHP care coordination services. The process should include: 1) checking available MCP data; and 2) asking members as part of

both the in-person member assessment during the eligibility/enrollment process and the assessment/care plan process.

The Targeted Engagement List (TEL) does not include members who are participating in the following programs:

- 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH);
- County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);
- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month; and
- Hospice.

Below is a summary of how HHP intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: 1) Members can receive services through both HHP and the other program; 2) Members must choose HHP or the other program; and 3) Members cannot receive HHP services.

1) Members Can Receive Services through BOTH HHP and the Other Program

- 1115 Waiver Whole Person Care Pilot Program
  Members participating in a Whole Person Care (WPC) Pilot Program may also be eligible for the HHP. DHCS has released specific guidance related to the interaction between the Health Homes Program and the WPC Pilot Program which can be found in Appendix K of this Program Guide.

- California Children's Services
  Children who are enrolled in the Children's Services program are eligible for the HHP.

- Specialty Mental Health and Drug Medi-Cal
  DHCS recognizes that coordination of behavioral health services will be a major component of HHP. HHP services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, trauma-informed care, oral health, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP members will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP members who receive behavioral health services have the capability to support the various needs of their members.

  For HHP members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented CB-CME is an appropriate setting for their HHP services. These CB-CMEs would typically be affiliated with an MCP.

  DHCS and stakeholders have noted that HHP members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary HHP services from their MHP's contracted provider acting as a designated CB-CME. To

facilitate care coordination for HHP members through a MHP-designated CB-CME, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform CB-CME HHP responsibilities through a contract with the MCPs in the county at the discretion of the MCP. This type of entity would perform the CB-CME HHP responsibilities for an HHP-eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated CB-CME instead of a CB-CME affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the CB-CME.

2) Members Must Choose HHP OR the Other Program

- Targeted Case Management
  County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and is duplicative of HHP. Members who are receiving TCM services have a choice of continuing TCM services or receiving HHP services.

  However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of HHP. The HHP provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

- 1915(c) Waiver Programs
  1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for HHP. There are comprehensive care management components within these programs that are duplicative of HHP services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving HHP services.
  The 1915(c) HCBS waiver programs include:
  HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), and Nursing Facility Acute Hospital (NF/AH).

- Cal MediConnect or Fee-for-Service Delivery Systems
  Members who are eligible for both Medi-Cal and Medicare are eligible for the HHP. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the HHP. However, HHP is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for-Service delivery systems to receive all their Medi-Cal services, including HHP services, through a regular Medi-Cal Managed Care Plan.

- Other Comprehensive Care Coordination Programs
  Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of HHP services, including programs that are operated or overseen by the MCP. Examples include, but

are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

3) Members CANNOT Receive HHP Services

- Nursing Facility Residents and Hospice Recipients
  Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the HHP.

B. HHP Outreach Requirements

MCPs will be responsible for engaging HHP-eligible members, using state-determined, Centers for Medicare & Medicaid Services (CMS)-approved criteria. Engagement of eligible HHP members will be critical for the program success. MCPs will link HHP members to one of the MCP's contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider (PCP) is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions.

1) MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities or delegate to CB-CMEs and provide appropriate oversight.

a. Capacity
   Have the capacity to engage and provide services to eligible members, including:
   1) Establish an engagement plan with appropriate modifications for members experiencing homelessness;
   2) Evaluate the TEL provided by DHCS;
   3) Attribute assigned HHP members to CB-CMEs;
   4) Ensure the engagement of members on the targeted engagement list;
   5) Secure and maintain record of the member's consent to participate in the program (which can be verbal); and
   6) Provide member resources (e.g. customer service, member grievance process) relating to HHP.

b. Engagement Process
   1) Have policies and procedures for identifying, locating, and engaging HHP-eligible members.
   2) Use the following strategies for engagement as appropriate and to the extent possible: mail; email; social media; texts; telephone; community outreach; and in-person meetings where the member lives, seeks care, or is accessible.
   3) Show active, meaningful and progressive attempts at member engagement each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face-to-face, mail, electronic, telephone), follow-up if the member presents to another partner in the HHP network, or using claims data to contact providers the member is known to use. Examples of acceptable engagement include:

a. Letter to member followed by phone call to member
b. Phone call to member, outreach to care delivery partners and social service partners
c. Street level outreach, including, but not limited to, where the member lives or is accessible

4) Establish a process for reviewing and excluding people from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines of having no substantial avoidable utilization or be enrolled in another acceptable care management program – see Reporting Template-Instructions for definition);
5) Report Members determined not appropriate for the HHP, along with a reason code, to DHCS.
6) DHCS will evaluate the MCP enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the targeted engagement list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.
7) Include housing navigators in the engagement process, at the MCP's discretion
8) Document the member engagement process
9) Develop a methodology and criteria used by the MCP or the CB-CME to stratify high, medium and low need members
10) Develop educational materials or scripts that you intend to develop to engage the member.
11) Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma-informed care standards
12) Have policies and procedures for the following:
    a. Required number and modalities of attempts made to engage member
    b. MCP's protocol for follow-up attempts
    c. MCP's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate

c. Assignment

MCPs will link HHP members to one of their contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions. MCP's and/or CB-CME's notification will inform the HHP member that they are eligible for HHP services, and identify their MCP and CB-CME. This notification will explain that HHP participation is voluntary, members have the opportunity to choose a different CB-CME, and HHP members can discontinue participation at any time. It will also explain the process for participation. In counties where multiple MCPs are available, the HHP member may change their MCP once per month in accordance with current MCP choice policies.

C. Priority Engagement Group

After the MCP has screened people who are inappropriate for HHP from the TEL based on the HHP requirements, MCPs are required to create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for priority engagement status will be at the MCP's discretion (upon approval by DHCS).

D. Referral

HHP services must be made available to all full scope Medi-Cal members without a share of cost who meet the DHCS-developed eligibility criteria, including those members dually eligible for Medicaid and Medicare. Providers, health plan staff, or other, non-provider community entities/care providers may refer eligible members to the member's assigned MCP to confirm if the member meets the eligibility criteria to receive HHP services. The Targeted Engagement List will be the primary method for identifying and engaging eligible HHP members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims history that identifies them as HHP eligible. Provider referral forms will indicate that the provider has verified that the member meets the HHP eligibility criteria. The provider will submit the referral form to the MCP for confirmation. MCP confirmation is required before an individual is deemed an HHP member and may receive HHP services from a CB-CME.

E. Consent

The member will be considered enrolled in the HHP once the member has given either verbal or written consent to participate in the program. The MCP or CB-CME will secure consents by the member to participate in HHP and authorize release of information to the extent required by law. Either the MCP or the CB-CME must maintain a record of these consents.

F. Disenrollment

If an eligible member has, or develops, an exclusionary criterion, cannot be engaged within a specified period, chooses not to participate, or fails to participate actively in HHP planning and coordination, the HHP member will be disenrolled from the HHP, and the MCP will discontinue CB-CME HHP funding for that member. Additionally, if the MCP determines that the member's eligible chronic conditions have become well-managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status – the HHP member will be disenrolled and the MCP will discontinue CB-CME HHP funding for that member.

A Notice of Action (NoA) Letter is required in all situations except for when an eligible member chooses not to participate. The eligible member may choose to participate in the HHP at any time.

G. Risk Grouping

The MCP will ensure that HHP member acuity will inform appropriate provision of HHP services. For example, MCP program criteria may include three, or more, risk groupings of the HHP members. Members in the higher acuity risk groupings (tiers) will receive more intensive HHP services. In addition, the HHP will include requirements to address the unique needs of members experiencing homelessness, as specified in AB 361.

H. Mental Health Services

MCPs will develop or amend existing Memoranda of Understanding with county Mental Health Plans (MHPs) to address HHP-specific information. DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018) to address the HHP-specific information that MCPs must include in new, or amended, MOUs. This MOU will be submitted to DHCS prior to the start of HHP implementation for the Serious Mental Illness or Serious Emotional Disturbance (SMI) population. Please see Appendix D - Readiness Requirements and Checklist for information on this deliverable.

I. Housing Services

MCPs will work with community resources to ensure seamless access to the delivery of housing support services. MCPs or contracted CB-CMEs must provide housing navigation services, not just referrals to housing. A Housing Navigator is required to be part of the HHP care team for members experiencing homelessness. HHP members must receive the following services:

1) Individual Housing Transition Services

Housing transition services assist beneficiaries with obtaining housing, such as individual outreach and assessments. These services include:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;
- Assisting with the housing application process. Assisting with the housing search process;
- Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
- Ensuring that the living environment is safe and ready for move-in;
- Assisting in arranging for and supporting the details of the move; and
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

2) Individual Housing and Tenancy Sustaining Services

Housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;
- Education and training on the roles, rights and responsibilities of the tenant and landlord;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;
- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

To the extent applicable, housing-based case management services provided to HHP members shall be consistent with the Housing First core components as described in Senate Bill (SB) 1380 Mitchel, Chapter 847, Statutes of 2016). Engagement to members potentially eligible for HHP or the provision of HHP housing-based case management services may not be restricted for individuals based on sobriety, completion of treatment, poor credit, financial history, criminal background, or housing readiness, unless they are determined ineligible for HHP or meet one or more of the DHCS defined HHP exclusionary criteria. HHP housing-based services shall incorporate a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of members' lives, where members are engaged in nonjudgmental communication regarding drug and alcohol use. Members should be offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if they so choose.

The HHP does not provide direct funding for housing. However, DHCS encourages MCPs to partner with housing organizations that incorporate the Housing First model into their case management and housing navigation services offered to members and to prioritize connecting HHP members with permanent housing options, when appropriate and available. For example, plans might explore collaborating with community-based organizations that are Housing First compliant, implement a requirement that housing services be provided consistent with Housing First components, encourage enhanced coordination with coordinated entry and assessment systems and/or allow receipt of referrals from the homeless crisis response system entities.

The goal is to integrate Housing First principles and components in an effort to enhance the provision of meaningful individual housing and tenancy-sustaining services to enrolled members.

J. Training

MCPs are required to ensure that the MCP and CB-CME staff who will be delivering HHP services receive the required HHP training prior to participating in the administration of the HHP. See Appendix C for training requirements.

K. Service Directory

MCPs or CB-CMEs must ensure a directory of community services and supports is developed, maintained, and is made available to all care coordinators to inform referring members to social services. The community services directory may be sourced from existing directories so long as it is available as a resource for CB-CMEs and care coordinators. This type of directory may be maintained by either the MCP or the CB-CME; however, the contracted MCP will ensure its availability.

L. Quality of Care

MCPs must incorporate HHP into existing quality management processes.

MCPs must have the capacity to collect and track information used to manage and evaluate the program, including tracking quality measures, and collecting, analyzing, and reporting financial measures, health status and other measures and outcome data to be reported for the State's evaluation process. The MCP will report core service metrics and the recommended core set of health care quality measures established by CMS, as well as the three utilization measures identified by CMS to assist with the overall federal health home evaluation. MCPs must report on the measures listed in the *Reporting Template, and provide* encounters for all HHP services.

M. Cultural Competency, Educational and Health Literacy

MCPs must incorporate HHP into existing policies and procedures related to ensuring that services, communication, and information provided to members are culturally appropriate, and meet health literacy, reading, harm-reduction, and trauma-informed care standards.

N. Member Communication

MCPs must incorporate HHP into existing policies and procedures regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers) into account in communicating with enrollee. DHCS and DMHC will review member materials from Knox-Keene plans through the usual process and criteria. DHCS will use a parallel process for non-Knox-Keene plans.

All notices to be sent by the MCP to Medi-Cal beneficiaries regarding the provision of HHP services will be submitted to DHCS for review.

Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. MCPs may use the DHCS HHP Member Handbook as an optional resource for examples of "best practice" member messaging (though the Handbook messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

MCPs must maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.

O. Members Experiencing Homelessness

MCPs must incorporate HHP-specific information into the appropriate policies and procedures for homeless members, including special provider and service requirements criteria (to achieve homeless experience requirements and other requirements per AB 361 and SB 1380), and engagement processes.

P. Reporting

MCP must have the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP encounters for services provided by the MCP and the CB-CMEs. See Appendix G (*Reporting Template);* and the *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting,* or later, for details.

CMS has established a core set of seven required health care quality measures and three utilization measures (see *Reporting Template* and *document* for details). Additional details can be found in the CMS technical specifications and resource manual. These measures were identified by CMS to assist with the overall federal health home evaluation.

MCPs will utilize the Supplemental Payment process to report members enrolled in HHP and to initiate capitation payments. See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information.

VII. Appendix

A. Appendix A – Example of an Acceptable Model Outreach Protocol

This Model Outreach Protocol is only offered as one example of a protocol that would be acceptable. It is meant to give the MCP ideas about how they might want to design their outreach protocols with the CB-CMEs. The details of this protocol are at the discretion of the MCP, as long as their protocol broadly meets DHCS' intent as stated in the body of the Program Guide and the Readiness Checklist.

SAMPLE PROTOCOL

The Medi-Cal managed care plan (MCP) will send an initial "Welcome Packet" to HHP-eligible members in accordance with their engagement process. After the initial packet is sent, the CB-CMEs will follow up with their HHP-eligible members through phone calls, in-person visits, and other modalities. Each CB-CME or the MCP will attempt to contact the member **five times** within 90 days after the initial packet is sent using various modes of communication (letters, calls, in-person meetings, etc.).

If the CB-CME does not have the capacity to conduct outreach to eligible members, MCP care coordination staff, including community health workers, will conduct the outreach to these members and note the outreach attempts in the members' record.

After five attempts, the CB-CME and the MCP will note the challenges with the active outreach and remind the PCP to discuss the HHP with the member at the next PCP visit. If the member declines HHP enrollment at the PCP visit, this will be noted in the EHR and the MCP will be notified.

If the CB-CME or the MCP learns that the contact information is out of date, efforts will be made to update that information using recent provider utilization data and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations. The CB-CME will also review members' housing history and work with the MCP Housing Program Manager to determine if that member can be reached at an alternative housing site or through a community-based organization.

CB-CMEs will track all outreach attempts within a three month intensive outreach period after the initial welcome letter is sent. The MCP will require that each outreach attempt and the outcome of each attempt be documented in the member's record in the HHP care management system and reported back to the MCP and DHCS. All outreach and engagement attempts will be evaluated by the care coordination team every 30 days within this three month period. The MCP will create policies and procedures for tracking and evaluating outreach and engagement efforts.

If a member declines participation in the HHP, or if their PCP determines that the member is not a good candidate for the HHP (using categories determined and provided by DHCS), this will be noted in the record in the HHP care management system to avoid repeated outreach

attempts. Members who do not enroll in the HHP will be noted, tracked in the MCP's data system and reported to DHCS. Members who graduate from the program will be disenrolled, which will be noted in the record, tracked in the data system, and reported to DHCS.

The MCP will create a mechanism for CB-CMEs and PCPs to identify potential HHP members who are not on the targeted engagement list and who meet the diagnostic and acuity criteria but not the utilization criteria. These individuals may be excellent candidates for the program to help prevent future avoidable health care utilization. In general, MCP will require CB-CMEs to justify the inclusion of the referred member into the program or onto the targeted engagement list. This would be reviewed by a medical director and/or nurse manager with experience in intensive case management to see if the member qualifies for the HHP or if they might be better served by another case management program, and if the rationale provided by the CB-CME or PCP justifies engagement and enrollment in the program.

Staff and Providers

The MCP will train MCP and CB-CME staff who may interact with HHP members, including customer service staff, 24-hour nurse line staff, and provider representatives, to ensure all member- and provider-facing staff are knowledgeable about the HHP, can answer questions and refer participating or eligible members or providers to the appropriate staff. MCP staff, CB-CME staff, providers and community providers are required to participate in webinars and trainings required by DHCS.

The MCP will work to educate all contracted providers, including providers at contracted CB-CMEs and providers from smaller clinics whose patients will receive HHP services through MCP care coordinators.

There will be on-the-ground community health workers who work in the local community and will visit members at their homes or community-based organizations where the members receive services. The MCP has made significant investments in developing this team of community health workers and they will be a key part of success in engaging and educating members on HHP.

Materials

The MCP will work with DHCS to educate providers, beneficiaries and key stakeholders to ensure strong member engagement and participation. The MCP will use outreach and education materials (flyers, brochures, sample email content, sample scripts, etc.) that are approved by DHCS. If the MCP is licensed by DMHC, these materials should additionally be filed with DMHC for review, as applicable. The MCP will also use existing communication channels to promote outreach and education opportunities for providers and members, such as informational webinars, trainings and tele-town halls.

At a minimum, the MCP will develop the following materials:

- Call scripts for Customer Service and 24-hour Nurse Advise Line;
- Member "Welcome Packet," including outreach letters and brochures;

- Appointment reminder letters for both medical and care coordination appointments;
- Content for both the member and provider sections of the MCP website; and
- Training guides for the MCP and CB-CME staff who interface with providers and members.

All member-facing materials for HHP will meet DHCS requirements for cultural competency and health literacy standards.

B. Appendix B – Targeted Engagement List Process

The Targeted Engagement List (TEL) Process identifies the Medi-Cal members that are the most appropriate candidates for the enhanced care coordination services in the Health Home Program (HHP). The TEL is sent to each participating Managed Care Plan (MCP) so that they can initiate engagement activities. This document provides additional details for the criteria and steps used in the TEL Process.

The data source for the TEL Process is DHCS's Data Warehouse. The Data Warehouse contains service level detail for most Medi-Cal programs, including managed care encounters, Fee-For-Service claims, Short-Doyle Mental Health services, Drug-Medi-Cal services, and others. MEDS eligibility information available in the Data Warehouse is also used in the TEL Process.

TEL Process – There are four main steps in the TEL Process, as follows:

1. SPA Eligibility Requirements for Chronic Condition Disease Identification – During the 24 months prior to the running of the TEL, if a member has at least two separate services on different dates for any of the following conditions it will be considered a chronic condition for the TEL. HHP chronic conditions include Asthma, Bipolar Disorder, Chronic Kidney Disease (CKD), Chronic Liver Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic or Congestive Heart Failure, Coronary Artery Disease, Dementia, Diabetes, Hypertension, Major Depression Disorders, Psychotic Disorders (including Schizophrenia), Substance Use Disorder, and Traumatic Brain Injury. The specific ICD-10 diagnosis codes for each chronic condition are listed below. The TEL process uses the primary and secondary diagnosis during the disease identification process.

2. SPA Eligibility Requirements for Chronic Condition Criteria. A member meets the chronic condition criteria if they have:
   2.1. Chronic Condition Criteria #1: At least two of the following: Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, Substance Use Disorder.
   2.2. Chronic Condition Criteria #2: Hypertension and one of the following: COPD, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure.
   2.3. Chronic Condition Criteria #3: One of the following: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders (including Schizophrenia).
   2.4. Chronic Condition Criteria #4: Asthma

3. SPA Eligibility Requirements – Acuity – These parameters ensure that potential HHP members are high utilizers of health services. A member must meet one of these acuity factors:

3.1. A high chronic condition predictive risk level (operationalized as three or more of the HHP eligible chronic conditions) or
3.2. At least one inpatient stay (not required to be related any particular condition*) in the 16-month period prior to the running of the TEL. (The inpatient stay algorithm is aligned with industry standards and the HEDIS inpatient algorithm) or
3.3. Three or more Emergency Department (ED) visits (not required to be related to any particular condition*) in a 16-month period prior to the running of the TEL. (The ED algorithm is aligned with industry standards and the HEDIS ED algorithm) or
3.4. Chronic Homelessness (there are no data parameters for this criteria. Members who only meet eligibility through this criteria will be identified solely through provider referral and MCP prior authorization)

* MCPs have the option to adjust this requirement.

4. HHP Enrollment Targeting and Exclusions – This step starts with the Medi-Cal members that meet the SPA chronic conditions and acuity eligibility requirements and determines if the members meet any of the specific program enrollment targeting and exclusionary criteria.:

a) Members that meet the eligibility requirements are excluded from the TEL, and <u>are excluded from participation in HHP unless their status changes</u>, if the members are identified as:

- Nursing Facility Residents
- Hospice Recipients
- Members with TCM
- Members in 1915 (c) programs
- Members in Fee-For-Service
- Members in PACE, SCAN, or AHF
- Members in Cal MediConnect

b) Members that meet the eligibility requirements are not included on the TEL (but could be enrolled through referral) if the members are identified as:

- Dually eligible members
- Members in CCS or GHPP
- Members with ESRD

TEL and TEL Supplement Reporting

The members that meet the eligibility requirements for chronic conditions and acuity will be reported to the managed care plans (MCPs) in either the TEL or the TEL Supplement. The TEL will contain all of the members that meet the SPA eligibility criteria through step 3 above and do not meet any of the specific program enrollment targeting and exclusionary criteria listed in step 4. The MCPs will use the TEL, their TEL verification process, and their internal priority

engagement rules to focus their enrollment activities and enroll the most appropriate members into HHP. The TEL Supplement will contain members that meet the SPA eligibility requirements for chronic condition criteria but are not included on the TEL. The TEL and the TEL Supplement will be provided within the same physical data set with the appropriate indicators.

TEL and TEL Supplement List Management

DHCS' expectations are that most of the HHP eligible members will be identified on the first TEL/TEL Supplement for an MCP in a region (first for chronic conditions, and six months later, for SMI) and most subsequent TEL/TEL Supplement files, at six month intervals, will have a smaller number of new members. To manage the members that appear on the TEL and the TEL Supplement, DHCS is considering the following parameters:

- Members may not appear on subsequent TEL/TEL Supplement files for an MCP because:
  - The member is no longer Medi-Cal eligible in MEDS
  - The member has changed MCPs
  - The member may not meet the disease identification or SPA eligibility requirements for chronic condition criteria
- Members may move from the TEL to the TEL Supplement and from the TEL Supplement to the TEL

TEL and SPA Assignment

DHCS is required to provide separate reporting to CMS for the HHP SMI SPA and the HHP Physical Health\SUD SPA. This requirement is reflected in the HHP implementation schedule. The TEL/TEL Supplement process includes all SPA-defined chronic conditions in the initial steps. In order to support the implementation schedule and MCP requests for additional TEL-related information, the initial TEL/TEL Supplement in each geographic implementation group will include both Physical health/SUD and SMI conditions.

However, members with only SMI conditions are not eligible for the first implementation in each County. The SMI-only members on the TEL/TEL Supplement are identified when Chronic Condition Criteria #3 equals '1' and Chronic Conditions Criteria #1, #2, and #4 are all equal to '0'. MCPs will be required to separately identify HHP members between physical health\SUD and SMI on the Supplemental Payment file sent to DHCS for payment purposes (See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information).

HHP TEL/TEL Supplement – Fixed-width Record Layout v1.3

Field Id	Field Name	Description	Length	Start	End	Data Type
1	TEL Report Date	Date of generation of the TEL and TEL Supplement (CCYYMMDD)	8	1	8	A

Field Id	Field Name	Description	Length	Start	End	Data Type
2	CIN	Client Identification Number is the unique Member ID assigned by MEDS.	9	9	17	A
3	Birth Date	Member's Birth date (CCYYMMDD format).	8	18	25	A
4	Age	Member's Age	3	26	28	A
5	Member's Last Name	Member's Last Name	20	29	48	A
6	Member's First Name	Member's First Name.	20	49	68	A
7	Member's Middle Initial	Member's Middle Initial	1	69	69	A
8	Member's Gender Code	Member's Gender Code	1	70	70	A
9	Member's County Code	Member's County Code	2	71	72	A
10	Member's County Code Description	Member's County Code Description	15	73	87	A
11	Member's Primary Aid Code	Member's Primary Aid Code	2	88	89	A
12	Medicare Part A Status	Medicare Part A Status	1	90	90	A
13	Medicare Part B Status	Medicare Part B Status	1	91	91	A
14	Medicare Part D Status	Medicare Part D Status	1	92	92	A
15	Plan Code for Member	Plan Code for Member	3	93	95	A
16	Asthma Chronic Condition	Member met the HHP criteria for Asthma ('1' for yes, '0' for no).	1	96	96	A
17	Bipolar Chronic Condition	Member met the HHP criteria for Bipolar ('1' for yes, '0' for no).	1	97	97	A
18	Chronic Congestive Heart Failure (DHF) Chronic Condition	Member met the HHP criteria for Chronic Congestive Heart Failure ('1' for yes, '0' for no).	1	98	98	A
19	Chronic Kidney Disease Chronic Condition	Member met the HHP criteria for Chronic Kidney Disease ('1' for yes, '0' for no).	1	99	99	A
20	Chronic Liver Disease Chronic Condition	Member met the HHP criteria for Chronic Liver Disease ('1' for yes, '0' for no).	1	100	100	A

Field Id	Field Name	Description	Length	Start	End	Data Type
21	Coronary Artery Disease Chronic Condition	Member met the HHP criteria for Coronary Artery Disease ('1' for yes, '0' for no).	1	101	101	A
22	Chronic Obstructive Pulmonary Disease Chronic Condition	Member met the HHP criteria for Chronic Obstructive Pulmonary Disease ('1' for yes, '0' for no).	1	102	102	A
23	Dementia Chronic Condition	Member met the HHP criteria for Dementia ('1' for yes, '0' for no).	1	103	103	A
24	Diabetes Chronic Condition	Member met the HHP criteria for Diabetes ('1' for yes, '0' for no).	1	104	104	A
25	Hypertension Chronic Condition	Member met the HHP criteria for Hypertension ('1' for yes, '0' for no).	1	105	105	A
26	Major Depression Disorders Disease Category	Member met the HHP criteria for Major Depression Disorders ('1' for yes, '0' for no).	1	106	106	A
27	Psychotic Disorders Chronic Condition	Member met the HHP criteria for Psychotic Disorders ('1' for yes, '0' for no).	1	107	107	A
28	Filler	Filler	1	108	108	A
29	Traumatic Brain Injury Chronic Condition	Member met the HHP criteria for Traumatic Brain Injury ('1' for yes, '0' for no).	1	109	109	A
30	Filler	Filler	2	110	111	A
31	Chronic Condition Criteria #1	Member met the HHP Chronic Condition Criteria #1 (At least two of the following conditions: Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, and Substance Use Disorder) ('1' for yes, '0' for no).	1	112	112	A

Field Id	Field Name	Description	Length	Start	End	Data Type
32	Chronic Condition Criteria #2	Member met the Chronic Condition Criteria #2 (Hypertension and at least one of the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease, or Chronic Congestive Heart Failure) ('1' for yes, '0' for no).	1	113	113	A
33	Chronic Condition Criteria #3	Member met Chronic Condition Criteria #3 (Any one of the following conditions: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders) ('1' for yes, '0' for no).	1	114	114	A
34	Chronic Condition Criteria #4	Member met Chronic Condition Criteria #4 (Asthma) ('1' for yes, '0' for no).	1	115	115	A
35	Count of Chronic Condition Criteria	A count of the number of Chronic Conditions Criteria the member met.	1	116	116	A
36	Acuity Factor #1	Member met acuity factor #1: three or more of the HHP eligible chronic conditions ('1' for yes, '0' for no).	1	117	117	A
37	Acuity Factor #2	Member met acuity factor #2: one or more inpatient stay ('1' for yes, '0' for no).	1	118	118	A
38	Acuity Factor #3	Member met acuity factor #3: three or more ED visits ('1' for yes, '0' for no).	1	119	119	A
39	Count of ED visits	The number of Emergency Department visits during the study period.	3	120	122	A
40	Latest ED visit DOS	The date of service for the most recent Emergency Department visit.	8	123	130	A
41	Count of Inpatient Admissions	The number of Inpatient Admissions during the study period.	3	131	133	A
42	Latest Inpatient Admission DOS	The date of service for the most recent Inpatient Admission.	8	134	141	A
43	Exclusion - Duals	The member is Dual Eligible ('1' for yes, '0' for no).	1	142	142	A
44	Exclusion - Hospice	The member had at least one service with one of the following revenue codes 0651, 0652, 0655, 0656, 0657, or with the following procedure code T2045 in the time period ('1' for yes, '0' for no).	1	143	143	A

Field Id	Field Name	Description	Length	Start	End	Data Type
45	Exclusion - ESRD	The member had at least one service with one of the following procedure codes in the time period, Z6004, Z6006, Z6012, Z6014, Z6016, Z6018, Z6022, Z6036, Z6038, Z6040, Z6030, 90967, 90968, 90969, 90970, 90989, 90993, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90935, 90937, 90945, 90947 ('1' for yes, '0' for no).	1	144	144	A
46	Exclusion - CCS	The member had at least one CCS End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	145	145	A
47	Exclusion - GHPP	The member had at least one GHPP End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	146	146	A
48	Exclusion - TCM	The member had at least one Targeted Case Management service in the time period (services where the Vendor Code was "92" or "93" ('1' for yes, '0' for no).	1	147	147	A
49	Exclusion - 1915c	The member met at least one of the following 1915c exclusions defined below, HIVAExcl, ALWExcl, DDExcl, IHOExcl, MSSPExcl, or PPC_Exclu ('1' for yes, '0' for no).	1	148	148	A
50	Exclusion - HIV/AIDS Waiver	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver exclusion. The member had at least one service in the time period where the Provider type was "073" and Procedure Code in (90837, 90846, 90847, 90847, G0156, G0299, G0300, S5130, S5165, S5170, S9470, T2003, T2022, T2025, T2026, T2028, T2029) ('1' for yes, '0' for no).	1	149	149	A
51	Exclusion - Assisted Living Waiver	Assisted Living Waiver (ALW) Exclusion. The member had at least one service in the time period where the Vendor Code In ("44" or "84"), and (Provider Type was "092", "093", or "014"), and (the Category of Service was 118 or 119) ('1' for yes, '0' for no).	1	150	150	A

Field Id	Field Name	Description	Length	Start	End	Data Type
52	Exclusion - Developmental Disabilities Waiver	HCBS Waiver for Californians with Developmental Disabilities (DD) exclusion. The member had at least one service in the time period where the Vendor Code was "76" and the Procedure Code in (Z9002, Z9003, Z9004, Z9005, Z9012, Z9014, Z9015, Z9016, Z9020, Z9021, Z9022, Z9023, Z9025, Z9025, Z9026, Z9026, Z9027, Z9028, Z9029, Z9030, Z9031, Z9032, Z9034, Z9038, Z9039, Z9043, Z9046, Z9047, Z9048, Z9050, Z9056, Z9058, Z9059, Z9060, Z9061, Z9062, Z9063, Z9064, Z9065, Z9066, Z9067, Z9069, Z9072, Z9073, Z9074, Z9075, Z9076, Z9077, Z9078, Z9079, Z9101, Z9102, Z9103, Z9104, Z9105, Z9106, Z9110, Z9111, Z9112, Z9113, Z9121, Z9122, Z9123, Z9124, Z9125, Z9126, Z9200, Z9202, Z9203, Z9204, Z9205, Z9206, Z9207, Z9208, Z9302, Z9303, Z9304, Z9305, Z9306, Z9307, Z9308, Z9310, Z9311, Z9312, Z9313, Z9314 ,Z9315, Z9400, Z9401, Z9402, Z9403, Z9404, Z9405, Z9406, Z9406, Z9407, Z9408, Z9999) ('1' for yes, '0' for no).	1	151	151	A
53	Exclusion - IHO/HCBA Waivers	In-Home Operations Waiver (IHO) / Home and Community-Based Alternatives (HCBA) exclusion. The member had at least one service in the time period where the Vendor Code was "71" and Provider type is “014, 059, 066, 067, 069, 078, 095”) or where the Vendor Code was "89" and the Special Program Code (SPECIAL_PGM_TYPE_CD was "3" (IHO Personal Care Services (WPCS)) ('1' for yes, '0' for no).	1	152	152	A

Field Id	Field Name	Description	Length	Start	End	Data Type
54	Exclusion - MSSP Waiver	Multipurpose Senior Services Program Waiver (MSSP) exclusion. The member had at least one service in the time period where the Vendor Code was "81", the Provider Type is '074', and the Procedure Code in (Z8550, Z8551, Z8552, Z8553, Z8554, Z8555, Z8556, Z8557, Z8558, Z8559, Z8560, Z8561, Z8562, Z8563, Z8564, Z8565, Z8566, Z8567, Z8568, Z8569, Z8570, Z8571, Z8572, Z8573, Z8574, Z8575, Z8576, Z8580, Z8581, Z8582, Z8583, Z8584, Z8585, Z8586, Z8587, Z8588, Z8589, Z8590, Z8591, Z8592, Z8593, Z8594, Z8595, Z8596, Z8597, Z8598, Z8599, Z8600, Z8601, Z8602, Z8603) ('1' for yes, '0' for no).	1	153	153	A
55	Exclusion - PPC Waiver	Pediatric Palliative Care (PPC) Waiver exclusion. During the observation period, the member in one of the following counties: Fresno, Los Angeles, Marin, Monterey, Orange, San Francisco, Santa Clara, Santa Cruz, Sonoma, or Ventura, the Provider Type is '014 or '039, the Category of Service is '120, and the Procedure Code is 'G9012' ('1' for yes, '0' for no).	1	154	154	A
56	Exclusion - PACE, SCAN, AHF	PACE, SCAN, and AHF exclusion. As of the last month, the member had one of the following Plan Codes: 050-065, 200-207, 601, or 915. ('1' for yes, '0' for no).	1	155	155	A
57	Exclusion - LTC Resident	Long Term Nursing Facility residents exclusion. As of the end of the study period the member had one of the following Long Term Care (Nursing Facility) Aid Codes: "13", "23", "53", or "63" ('1' for yes, '0' for no).	1	156	156	A
58	Exclusion - FFS	Fee-For-Service exclusion. As of the end of the study period the member was in Fee For Service (Plan Code 000) ('1' for yes, '0' for no).	1	157	157	A
59	Count of Exclusions	A count of the number of Exclusions for which the member met the requirements.	2	158	159	A
60	TEL Indicator	A value of "1" indicates a TEL record; a value of "0" indicates a TEL Supplement record	1	160	160	A

C. Appendix C – Training Requirements

This section outlines training that MCP and CB-CME staff who will be delivering HHP services are required to receive prior to participating in the administration of the HHP. It also includes recommendations for training CB-CME staff on several core competencies.

Required HHP Trainings for Prior to HHP Implementation
MCP and CB-CME staff who will be delivering HHP services are required to receive HHP-specific training prior to HHP implementation. The required training topics described below cover basic program components. DHCS provided PowerPoint training materials that MCPs can leverage for their required trainings. However, it is also acceptable for an MCP to use non-DHCS developed training materials to satisfy one, or more, of the requirements. DHCS-developed training materials are saved on both the portal and DHCS' Health Homes Program website.

MCPs must be prepared to follow the required high-level trainings with more specific HHP operational training for their staff and CB-CME staff that provide HHP services. This should include MCP-specific information on operations, workflows, how HHP intersects with MCP care coordination initiatives, data reporting, and other implementation issues. DHCS and Harbage Consulting will work with each MCP to discuss their needs and the best approach for providing the required trainings.

The required HHP training topics are:

1. **Health Homes Program Overview**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on the program. Required training modules shall describe the goals and scope of the HHP, team member roles and how they should work together, the services that should be provided, and how HHP intersects with other California state care coordination programs. The training shall introduce topics related to caring for the populations served under HHP, including those with chronic conditions and homeless individuals, and the impact of social determinants of health on patients.

2. **Health Action Plan, Care Coordination, and Care Transitions within the Health Homes Program**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on best practices for working with members and providers to design and implement the Health Action Plan, conduct care coordination activities, and support patient transitions between different levels of care.

Required training shall cover approaches and best practices for developing and implementing a Health Action Plan and providing patient-centered care, taking into account the individual's preferences, values, and unique needs. It shall also cover best practices for care management for specific chronic diseases that are prevalent in the patient population and best practices for serving the SMI population.

Staff shall be trained in best practices for coordinating care across care settings, with particular focus on medical care, behavioral health services, and services addressing social determinants of health and housing. Training shall include effective strategies for care transitions, including best practices for reducing hospital readmissions and medication errors at care transitions.

3. **Community Resources and Referrals** (required for care coordinators and housing navigators)

This training shall provide information about available community resources, how to develop relationships with community partners, and best practices for connecting members to community services. This training is required for MCP and CB-CME care coordinators and housing navigators.

MCPs are encouraged to provide additional training and/or guidance about specific local and community organizations and resources available to the CB-CME staff.

Recommended but Optional Training for CB-CME Staff on Core Competencies

DHCS recommends that relevant MCP and CB-CME staff receive training on the following core competencies in order to successfully implement HHP. DHCS plans to provide trainings and/or resources on these topics, which will be saved on the portal and available on-demand.

1) Special Populations (homelessness, domestic violence, SMI, etc.)

Team members should have access to training and resources specific to the patient populations they serve.

2) Social Determinants of Health

Trainings and resources related to social determinants of health should be made available for team members. Social determinants of health include gender, age, education, income and employment, social/cultural networks, housing and physical environments and other factors that impact health outcomes and access to care.

3) Motivational Interviewing

Motivational interviewing is a communication technique that seeks to elicit an individual's internal motivation to make set and accomplish positive goals. The technique uses a non-confrontational, collaborative approach to help the patient find his or her own motivation and initiate change. The patient is empowered to make personal choices, resulting in increased likelihood of compliance with care plans.

4) Trauma-informed Care

Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma. Trauma-informed care emphasizes safety (physical, psychological and emotional) for patients and providers and seeks to empower patients with self-care tools.

5) Health Literacy Assessment

Health literacy refers to a patient's capacity to find and understand health information and services in order to make informed health decisions. Assessment of patient health literacy is essential to the creation of a patient-centered care plan.

6) Information Sharing

Team members should be trained on requirements related to sharing member information and data with other entities for the purpose of care coordination. These entities include the MCP, CB-CMEs, the care team, the county, hospitals, other providers, and community-based organizations including housing organizations.

D. Appendix D – Readiness Requirements and Checklist

Readiness Requirements and Checklist

This checklist is not intended to be all-inclusive. Additional information as needed may be requested by the Department.

General Instructions

Thank you for your interest in participating in the Health Homes Program (HHP). To ensure that Medi-Cal managed care health plans (MCPs) are ready to implement the Health Homes Program, MCPs must submit the documentation listed below and attest that other program requirements have been completed. **There are multiple deadlines for submissions for each implementing MCP group. Please see Appendix I for the HHP Implementation Schedule by group. Submission deadlines for each group are as follows:**

1. **Group 1 – March 1, 2018; May 1, 2018; and November 1, 2018.**
2. **Group 2 – September 1, 2018; November 1, 2018; February 1, 2019; and May 1, 2019.**
3. **Group 3.1 – January 1, 2019; April 1, 2019; July 1, 2019; and October 1, 2019.**
4. **Group 3.2 – March 1, 2019; May 1, 2019; August 1, 2019; and November 1, 2019.**
5. **Group 4 – September 1, 2019; November 1, 2019; February 1, 2020; and May 1, 2020.**

List of Deliverables:

Policies and Procedures (P&Ps) and Attestations: Section I – HHP Infrastructure (Deliverables #1 – 3), Section II – HHP Services (Deliverables #4 – 5), Section IV – General HHP Operations (Deliverables #7 – 10 and 12), and the Attestations (Deliverable #13)

Network: Section III – Network (Deliverable #6.1, 6.3, 6.4, 6.5)

SMI– MHP-MOU: Section IV – General HHP Operations, MHP-MOU (Deliverable #11.1)

SMI Network: Section III – Network (Deliverables #6.2a and 6.2b)

Group	Counties	Deliverable Due Dates		Deliverable Approval Dates
Group 1	San Francisco	**P&Ps**:	3/1/18	5/1/18
		Network:	5/1/18	6/1/18
		SMI Deliverables:	11/1/18	12/1/18
Group 2	Riverside San Bernardino	**P&Ps**:	9/1/18	11/1/18
		Network:	11/1/18	12/1/18
		SMI MHP-MOU:	2/1/19	3/1/19
		SMI Network:	5/1/19	6/1/19
Group 3.1	Imperial Santa Clara	**P&Ps**:	1/1/19	5/1/19
		Network:	4/1/19	6/1/19
		SMI MHP-MOU:	7/1/19	8/1/19
		SMI Network:	10/1/19	12/1/19
Group 3.2	Alameda Kern Los Angeles Sacramento San Diego Tulare	**P&Ps**:	3/1/19	5/1/19
		Network:	5/1/19	6/1/19
		SMI MHP-MOU:	8/1/19	9/1/19
		SMI Network:	11/1/19	12/1/19
Group 4	Orange	**P&Ps**:	9/1/19	11/1/19
		Network:	11/1/19	12/1/19
		SMI MHP-MOU:	2/1/20	3/1/20
		SMI Network:	5/1/20	6/1/20

DHCS expects the deliverables to be submitted in the form of MCP policies and procedures except for the organizational chart, assessment tool, health action plan template, network adequacy tables, and CB-CME subcontract. MCPs may develop standalone policies and procedures for the HHP and/or may incorporate HHP into existing policies and procedures.

MCPs are to submit a separate set of deliverables for each county they are implementing HHP in. If one or several deliverables cover multiple counties, MCPs are not required to submit the deliverable for each county. However, the MCP must indicate which counties the deliverable applies to during the submission process. The network tables that MCPs submit are to be separated by county.

For MCPs in multiple groups, the plan should not resubmit deliverables already approved for a prior group, unless changes have been made.

When submitting existing policies & procedures with HHP-related revisions, please use the "track changes" function in Word, or strike-thru/underline equivalent in other applications, to show deletions and additions. Other forms of documentation are also permitted to supplement MCP policies and procedures. If single documents are used to demonstrate compliance with multiple requirements/deliverables, please provide a crosswalk with the specific location for each deliverable.

Please see the *"Medi-Cal Health Homes Program: Program Guide"* (Program *Guide)* for Health Home Program requirements that correspond to this Readiness Checklist.

Submission Requirements

MCPs should follow the regular process for submitting required deliverables to their current Contract manager(s). Please submit HHP-related deliverables to 2PlanDeliverables@dhcs.ca.gov and copy the HHP mailbox at hhp@dhcs.ca.gov.

For each submission, please provide the Plan's Name and the primary Contact Person's name and telephone number.

In addition, when submitting, please use the following email subject line and file naming conventions:

- In the subject line of the email, please note that these are HHP Deliverables by using the following subject line convention:
  "HHP Deliverable 1"; "HHP Deliverables 2 and 3"; etc.

- Please use the following file naming convention:
  [plan name and deliverable number]

The Contact Person is responsible for ensuring that all documentation and attestations are accurate. Questions may be directed to hhp@dhcs.ca.gov. DHCS will provide additional information as it becomes available, and may request additional information at a later date.

I. HHP Infrastructure

1. Organizational Model:

1.1 Submit MCP's policies and procedures describing the HHP infrastructure, the roles and division of labor between the MCP and Community-Based Care Management Entities (CB-CMEs), and whether the MCP delegates any responsibilities to other entities.

1.2 Organizational chart illustrating the HHP infrastructure.

2. Staffing:

2.1 Submit MCP's policies and procedures describing the staffing plan for MCP and CB-CMEs, including care coordinators, community health workers, and housing navigator(s). The care coordinator ratio requirements are included in the Program Guide; however, if an MCP is interested in using a staffing model that de-emphasizes the care coordinator and instead emphasizes the roles of other team members, please describe the model here and DHCS will consider how to handle the care coordinator ratio.

The participation of community health workers in appropriate roles is recommended but not required.

2.2 Job descriptions for care coordination staff, including MCP and CB-CME staff, as appropriate.

3. Health Information Technology/Data and Information Sharing:

3.1 Submit MCP's policies and procedures describing how information is shared among the entire care team (including the member, CB-CME, and MCP), including whether EHR/HIT/HIE, or other methods, are used regarding the following activities:

a. Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management – standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement. Include other methods if electronic means of collection are not used.

b. Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.
   - Telehealth services including remote patient monitoring.

c. Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER. Include other methods if an electronic process is not used.

- Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR. Include other methods if electronic sharing is not used.
- Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.

d. Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.

e. Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.
   - Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used.

II. HHP Services

4. Care Management:

5.1 Submit the assessment template or tool reflective of HHP-required elements such as housing instability, palliative care, and trauma-informed care.

5.2 Submit the Health Action Plan (HAP) template.

5.3 Submit MCP's policies and procedures for conducting care management, including how the MCP, in conjunction with contracted CB-CME, will:
- Develop and implement an HHP member assessment and HAP requirements and process, with enrollee and caregiver participation;
- Design the multi-disciplinary care team composition and process;
- Manage the communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; and
- Maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.
- Maintain a process for referring to other agencies, such as long term services and supports (LTSS) or behavioral health agencies, as appropriate.
- Disenroll members from HHP who no longer qualify for or require HHP services.

5. Care Transitions:

5.1 Submit MCP's policies and procedures for conducting care transitions, including discharge-planning workflows.

III. HHP Network

6. MCP Duties/Responsibilities - Health Homes Program Network

6.1 Physical Conditions and SUD implementation

Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected enrollment and capacity as of the program launch date and as of the last day of each quarter in the first year for the Physical Chronic Conditions/SUD implementation. "Projected capacity" is the maximum caseload of the MCP's Physical Chronic Conditions/SUD HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of Physical Chronic Conditions/SUD HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable is due as a part of the Network Deliverables submission.

Please provide expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – Physical Conditions and SUD**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

Note: A separate DMHC network review specific to HHP will not be conducted; however, DMHC will continue to conduct regular Knox-Keene Act required network reviews through DMHC established processes.

6.2 SMI Implementation

a. Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected HHP enrollment and capacity for these CB-CMEs as of the program launch date and as of the last day of each quarter in the first year for the SMI implementation. "Projected capacity" is the maximum caseload of the MCP's SMI HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of SMI HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable update is due as a part of the SMI Deliverables submission.

Please provide the expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – SMI**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

b. Provide a description of how behavioral health providers are incorporated into the HHP service delivery model. This deliverable is due as a part of the SMI Deliverables submission.

6.3 If applicable, provide any MCP-specific CB-CME qualifications (beyond the CB-CME qualifications listed in section V.B, CB-CME Qualifications) that the MCP requires for the CB-CME to contract for HHP Services. This deliverable is due as a part of the Network Deliverables submission.

6.4 Submit CB-CME oversight policies and procedures, including monitoring, corrective action, progressive consequences for continued non-compliance, auditing care coordination conducted by CB-CMEs. This deliverable is due as part of the Network Deliverables Submission.

6.5 Submit CB-CME subcontract boilerplate that complies with the DHCS MCP contract requirements and includes: 1) Business Associate Agreement that allows for information and data sharing between MCP and CB-CME, 2) CB-CME to provide services in accordance with requirements in this Program Guide, and 3) CB-CME to complete DHCS/MCP required training. **If submitting prior DHCS approved subcontract boilerplate with HHP-related revisions, please use the "track changes" function in Word, or the "strike-through/underline" equivalent in other applications, to show deletions and additions.** This deliverable is due as part of the Network Deliverables Submission.

Note: MCP must have DHCS-approved subcontracts or subcontract amendments with a sufficient number of CB-CMEs to serve its HHP enrollees.

IV. General HHP Operations

7. Non-Duplication of Care Coordination Services:

7.1 Submit MCP's policies and procedures for ensuring that members are not enrolled in another Medi-Cal care coordination program that would disqualify them from receiving HHP services (see Program Guide for requirements).

8/9. HHP Outreach Requirements

8.1 Member Engagement:

Submit MCP's policies and procedures that include the following:

- Protocols for a progressive outreach campaign (see Program Guide Appendix A for model outreach campaign protocols)
- Process for assisting members who require additional prompting or guidance to participate;
- Process for conducting outreach to homeless individuals;
- Process for reviewing and excluding names from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines

of having no substantial avoidable utilization **or** enrollment in another acceptable care management program – see Reporting Template-Instructions for definition);

- After people have been excluded from the TEL based on the process above, the process and criteria for identifying a "priority engagement group" or ranking process within the remaining TEL members. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for 'priority engagement' status will be at the MCP's discretion (upon approval by DHCS) with the goal of engaging and serving TEL members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

9.1 Member Notices:

All beneficiary notices to be sent by the MCP regarding the HHP should be filed for DHCS review. If the MCP is licensed by DMHC, these notices should additionally be filed with DMHC for review. DHCS is aligning with DMHC requirements regarding notice review, and DMHC requires MCPs to file all advertisements for review. All outreach materials and scripts that will be distributed should be filed prior to use by the MCP. Submission through this readiness checklist process will begin the DHCS notice review/approval process. MCPs may provide notices for DHCS review at any time prior to the member notices deliverable due date.

Note: Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. DHCS' HHP Beneficiary Toolkit is an optional resource for the MCPs for examples of 'best practice' member messaging (though the HHP Member Toolkit messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

10. Risk Grouping:

10.1 Submit MCP's policies and procedures for ensuring that HHP members receive the appropriate services at the appropriate intensity level, including tiering of services based on risk grouping and the associated payment structure (but not amounts). See Section V. Health Homes Program Network, G. Risk Grouping in this Program Guide for additional information.

11. Mental Health Services:

11.1 Signed local Mental Health Plan (MHP) Health Memorandum of Understanding (MHP-MOU) to ensure seamless access and delivery of mental health services. The MHP-MOU must be in place as of the date of implementation of HHP for members

with SMI conditions. MCPs will develop or amend existing MOUs with county MHPs to address HHP-specific information.

DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018), including Attachment 2 of this APL, to address the HHP-specific information that MCPs must include in new, or amended, MOUs. MCP must submit the new or amended MHP-MOU by November 1, 2018 for Group 1 MCPs; February 1, 2019, for Group 2 MCPs; July 1, 2019 for Group 3.1 MCPs; and August 1, 2019 for Group 3.2 MCPs.

12. Housing Services:

12.1 Submit MCP's policies and procedures for providing the required housing services, including how the MCP will identify and work with community resources to ensure seamless access to delivery of housing support services. MCPs must provide housing navigation services, not just referrals to housing. (See Program Guide for requirements.)

13. Health Homes Program Readiness – Attestations

The operational process attestations below reflect the MCP's commitment to being fully prepared as of the HHP implementation date. Please check the boxes and sign below to indicate MCP's compliance with the following readiness requirements for the Health Homes Program.

☐ **F. Training**: Attest (check the box) that the MCP and CB-CMEs will complete all DHCS-required HHP training prior to participating in the administration of the HHP, as outlined in the *Program Guide*.

☐ **G. Service Directory**: Attest (check the box) that the MCP or the CB-CME(s) has completed and will maintain a directory of community services and supports that is available to all CB-CMEs and care coordinators.

☐ **H. Quality of Care**: Attest (check the box) that the MCP has incorporated HHP into existing quality management processes.

☐ **I. Cultural Competency, Educational and Health Literacy**: Attest (check the box) that the MCP has incorporated HHP into existing Policies & Procedures on these topics.

☐ **J. Member Communication**: Attest (check the box) that the MCP has incorporated HHP into existing policies regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers), into account in communicating with enrollee.

☐ **K. Members Experiencing Homelessness**: Attest (check the box) that the MCP has incorporated HHP-specific information into the appropriate Policies & Procedures for homeless members, including special service requirements, provider criteria (to comply with homeless experience requirements per AB 361), and engagement processes.

☐ **L. Reporting**: Attest (check the box) that the MCP has the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP service encounters for services provided by the MCP and the CB-CMEs (see *Program Guide* and *reporting template* for reporting requirements).

☐ **M. Service Requirements**: Attest (check the box) that the MCP will comply with all the with all service requirements, including for the six core services and the additional service requirements listed in the Program Guide.

I am authorized to make this attestation on behalf of:

_____	_____
Managed Care Plan	Signature of Authorized Representative
_____	_____
Date	Name of Authorized Representative
	_____
	Title of Authorized Representative

E. Appendix E – Service Codes for the Health Homes Program

DHCS has defined the ACA 2703 Health Home Program (HHP) service codes for use on encounters and for other purposes. The HHP is required to utilize HIPAA-compliant coding standards. This revised coding scheme incorporates comments received on the initial proposed coding scheme released in October 2016. The HHP team and the DHCS Office of HIPAA Compliance identified CPT and HCPCS codes for HHP. In addition, the HHP team investigated other potential codes and reviewed codes used by a few other states.

DHCS initially selected HCPCS code G0506 for HHP, however it was found to conflict with National Correct Coding Initiative rules. DHCS instead adopted HCPCS code G9008 effective as of 10/1/2018. The definition of G9008 is as follows: Coordinated care fee, physician coordinated care oversight services. G9008 along with seven different modifiers are listed in the table below for the HHP services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Supports). This coding scheme uses HIPAA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other HHP services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The HHP coding scheme is as follows:

HHP Service	**HCPCS Code**	**Modifier**	**Units of Service (UOS)**
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Telehealth and Group Visits

Regarding the use of the HHP HCPCS code and modifiers for HHP services provided via Telehealth and group visits – specifically, if MCPs may submit HHP encounters for telehealth and group visits using the HHP HCPCS code and modifiers for HHP in-person visits and if they may be used to satisfy the in-person visit ratio requirement – DHCS offers the following clarifying guidance.

Telehealth visits generally may not be used to meet the in-person visit ratio requirement for HHP. However, on a case by case basis, if an MCP has certain circumstances that necessitate the use of a high volume of telehealth visits for HHP, and the MCP is unable to meet the HHP in-person visit requirement because of the high-volume use of telehealth, DHCS will evaluate the circumstances and may allow the MCP to utilize some telehealth visits to meet the in-person visit requirement.

DHCS expects that group visits to be primarily used for health promotion and educational purposes as opposed to one-on-one HHP care coordination. However, if there is a one-on-one in-person component to the group visit in which the provision of any of the six core HHP services are provided, this may be reported as a separate HHP in-person visit encounter.

F. Appendix F – Evidence of Coverage Template

Description:

<Plan Name> covers Health Homes Program (HHP) services for Members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long term services and supports (LTSS) for Members with chronic conditions.

You may be contacted if you qualify for the program. You can also call <Plan Name>, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call <Plan Name> to find out the conditions that qualify; and
- You meet one of the following:
  - You have three or more of the HHP eligible chronic conditions
  - You stayed in the hospital in the last year
  - You visited the emergency department three or more times in the last year; or
  - You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP Services:

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers, and others, to coordinate your care. <Plan Name> provides HHP services, which include:

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

Cost to Member:

There is no cost to the Member for HHP services.

G. Appendix G – Reporting Template Excerpt

The below is an excerpt from the complete Reporting Template that MCPs will use to submit specific required data. For descriptions of data elements, please see Reporting Template.

Note: CPB = Controlling High Blood Pressure; CDF = Screening for Clinical Depression and Follow-up Plan; SMI = Serious Mental Illness/Serious Emotional Disturbance.

Health Home Program (HHP) Reporting Instructions

These instructions outline the requirements, references, and headings/categories for the following reporting template: Health Home Program Reporting Template. Reporting is required per the managed care contract.

• Data must be submitted in Excel (.xlsx). Do not submit data in .pdf, .xls, .csv, .txt, or any other format than .xlsx.

• The three months of data must be combined into one figure to represent the quarter, with the exception of member level Homeless and Housing reports and annual reports.

• Each MCP must submit only one file per reporting period that includes all counties the MCP operates in. All subcontractors must be rolled up into the main MCP's data.

• MCPs will certify the HHPQuarterlyReports or data submissions using the existing monthly data certification process with its respective DHCS Contract Manager to confirm all information submitted is complete and accurate. MCP will maintain documentation supporting the reported information.

Quarterly reports are due 60 days after the end of the quarter. Annual reports are due with Q1 reports. Member-level detail Homeless/Housing reports are due semi-annually, with the Q2 and Q4 reports. When the due date falls on Saturday, Sunday or a holiday, data must be submitted by COB the business day before the due date. For reference, the calendar-year quarters are listed below:

• Q1 and Annual – January, February, and March - due May 31

• Q2 and Member-level Homeless/Housing – April, May, and June - due August 31

• Q3 – July, August, and September - due November 30

• Q4 and Member-level Homeless/Housing – October, November, and December - due February 28

Unless otherwise noted, all "days" are calendar days.

Reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). Reports must use the following file naming convention: MCP name.HHPQuarterlyReport.Year.Quarter.DueDate.xlsx

[MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.xlsx.]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181130.xls. DHCS will not acknowledge or accept any email submissions.

All report revisions are subject to DHCS review and approval.

• DHCS will notify MCPs if revised reports must be submitted to correct data errors such as incorrect file naming conventions, incomplete data/columns fields, incorrect data, etc.

• Revised reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov).

• Revised reports must be submitted as a complete quarterly file. Partial files without all the required information and data will be rejected and must be resubmitted. Each quarter of data must be submitted separately. MCP must include an explanation in the HHP comments tab describing the changes and the reason for revision.

• Revised reports must use the following file naming convention: MCPName.HHPQuarterlyReport.Year.QuarterNumber.DueDate.RevisionNumber.xlsx [MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.REV#.xlsx]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181230.REV1.xlsx. to your designated folder in the "DHCS-MCQMD-Data/MCP" folder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). The revised file should be submitted as a separate file.

• Final corrections to quarterly reports must occur no later than 90 days after the end of the calendar year for corrections on the previous year's quarterly reports unless the Department requests a revised file.

Definitions:

CB-CME: Community Based Care Management Entity

HAP: Health Action Plan

Homeless and Chronically Homeless: see CA Welfare & Institution Code § 14127(e)

Housing Services:
https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf - see "Individual Housing Transition Services" and "Individual Housing & Tenancy Sustaining Services" on pages 3-4.

For the purposes of this document, the following definitions will apply:

- **HHP Member**: a Medi-Cal beneficiary currently enrolled in a Medi-Cal Managed Care Plan and a Health Homes Program.

- **Member**: a Medi-Cal Managed Care Plan member not currently enrolled in a Health Homes Program.

- **Individual**: Medi-Cal beneficiary or other eligible person who may not be currently enrolled in a Medi-Cal Managed Care Plan or a Health Homes Program. E.g., FFS beneficiary. May also apply to person not currently enrolled in Medi-Cal.

Definitions of Exclusionary Reasons for Non-Enrollment: The following are the allowable reasons, with definitions, for which a Medi-Cal member may be excluded from, or not enrolled into, a local Health Homes Program (HHP). These definitions are used by DHCS and its HHP partners. For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage. See the definition of Targeted Engagement Process below for additional information.

I. ***Unsafe Environment***: for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ED: After reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment or deliver HHP services, such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff.

Individual: Member engagement/enrollment efforts, or delivery of HHP services, cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

II. ***Declined participation***: After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate in HHP.

III. ***Unsuccessful engagement***: HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self-available, or is un-cooperative. Accurate contact information is not available for the member. This occurs before enrollment.

IV. ***Well-managed***: An assessment, which may include a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.

V. ***Participation in duplicative programs or programs excluded for HHP participation due to DHCS policy***: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following:

1. Duplicative Programs

a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH)

b. Targeted Case Management (TCM) – County, not Mental Health TCM

c. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF)

2. Programs excluded by DHCS Policy

a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month.

b. Hospice

c. Fee-For-Service

VI. ***Targeted Engagement Process***: The MCPs DHCS-approved process by which MCPs identify and prioritize individuals for engagement by using DHCS-provided Targeted Engagement List (TEL) and/or MCP member data.

For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage, that is a result of the above mentioned DHCS-approved process.

1. Health Home Program Enrollment Reporting	
***Note:* Only report one (1) exclusionary reason per member excluded from the Program.**	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number MCP excluded because not eligible - well-managed (Column C)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because not eligible due to MCP assessment determining well managed. The CB-CME and/or the MCP can further define, but well-managed means (a) members with HHP chronic conditions that do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation; or (b) members that are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.
Number MCP excluded because declined to participate (Column D)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because they declined to participate. After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate, or to continue to participate, in HHP.
Number MCP excluded because of unsuccessful engagement (Column E)	Enter the number of members MCP excluded via the targeted engagement process the quarter because of unsuccessful engagement. HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self available; is un-cooperative; or accurate contact information is not available for the member. This occurs before enrollment.

Number MCP excluded because duplicative program (Column F)	Enter the number of members MCP excluded via the targeted engagement process during the quarter due to being in another program that provides care management services: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following: 1. Duplicative Programs a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH) b. Targeted Case Management (TCM) – County, not Mental Health TCM 2. Programs excluded by DHCS Policy a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month. b. Hospice 3. Additional programs the MCP determines are duplicative as described in their progressive engagement policy
Number MCP excluded because unsafe behavior or environment (Column G)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because of an unsafe behavior or environment. Unsafe includes Environment (for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ER): after reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff; and Individual: Member engagement/enrollment efforts cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

Number MCP excluded because not enrolled in Medi-Cal at MCP (Column H)	Enter the number of individuals MCP excluded from via the targeted engagement process list during the quarter because they are not enrolled in Medi-Cal at the Managed Care Plan. Reasons can include, but may not be limited to, the following: a. Fee-For-Service b. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF) c. Member is deceased
Number externally referred & enrolled (Column I)	Enter the number of members not part of the plan's targeted engagement process, referred to the MCP, that were enrolled. The referral process is initiated by an external provider or organization when an individual is initially assessed to be a candidate for HHP and therefore is referred to the MCP for approval. Upon MCP review and evaluation, if the individual is approved for HHP and enrolled, they would be included in this measure. If they are not approved for enrollment in HHP, they would be reported in the following measure.
Number externally referred but excluded (Column J)	Enter the number of individuals not part of the plan's targeted engagement process, referred to the MCP, that were excluded. Exclusion reasons include reasons identified in columns C-H. Do not add these exclusions to the counts in Columns C-H.
Average monthly number of dedicated care coordination FTEs (Column K)	Enter the average monthly number of care coordinators for the quarter. Only count FTEs dedicated to care coordination activities. The counts are taken at a point in time, which will be the last day of each month in the quarter, and averaged across the 3 months in the quarter to get this average quarterly number.
2. Health Home Program Member Activity Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number initial HAP completed within 90 days (Column C)	Numerator: Enter the number of HHP members that had their initial HAP completed during the quarter and the HAP was completed within 90 days of enrollment.
Number initial HAP completed (Column D)	Denominator: Enter the number of HHP members that had their initial HAP completed during the quarter.

3. Health Home Program Homeless/Housing Member Level Detail	
Note: This tab is to be submitted semi-annually in the Q2 report and Q4 report of every year. The Q2 report (due 8/31) will include data for January through June of the current calendar year. The Q4 Report (due 2/28) will include data for July through December of the previous calendar year.	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for the county and plan code the plan operates in. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and semi-annual reporting period. For example, the second reporting period of 2019 will be entered as 2019 Q3-Q4.
Member CIN (Column C)	Enter the Member's Client Identification Number (CIN) for all members that meet Column G and/or Column I.
Member Last Name (Column D)	Enter the Member's Last Name.
Member First Name (Column E)	Enter the Member's First Name.
Member Date of Birth (DOB) (Column F)	Enter the Member's Date of Birth (DOB) using format MM/DD/YYYY.
Homeless HHP Members and HHP Members at Risk for Homelessness During This Reporting Period (Column G)	Indicate whether the HHP enrolled member met the Federal definition of Homeless or required tenancy sustaining services at any point during the reporting period. Enter "Yes" or "No."
Received Housing Services During This Reporting Period (Column H)	Indicate whether the HHP enrolled member received housing services at any point during the reporting period. Enter "Yes" or "No."
Homeless Health Homes Members In Any Enrollment Period (Column I)	Indicate whether the HHP enrolled member met the Federal definition of Homeless at any point during their enrollment in the HHP. Enter "Yes" or "No."

HHP Members who are no longer Homeless On Last Day of This Reporting Period (Column J)	Indicate the HHP enrolled member no longer meets the Federal definition of Homeless, as of the last day of the reporting period. If the member was disenrolled during the reporting period, report as of their last date of enrollment. Enter "Yes" or "No."
4. Health Home Program Network Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.
CB-CME NPI # (Column C)	Enter all CB-CME NPI numbers that were contracted as of the last day of the quarter. Enter each CB-CME NPI number in each county on its own row. For example, if a MCP is contracted with a CB-CME that operates in two counties, there would be two rows for that NPI with each row having a different plan code & county. DHCS assumes that all lead CB-CMEs will have a NPI or be the MCP; if a CB-CME does not have an NPI #, please reach out to DHCS for further discussion. This is a measure of the prime contract with the MCP for care management duties, not engagement subcontractors or housing subcontractors.
Capacity for each CB-CME (Column D)	Enter the capacity for assigned HHP members for each CB-CME contracted in each county during the quarter. If a CB-CME operates in more than one county, separate the projected capacity for each county. Capacity is defined as the number of HHP members the CB-CME will be able to serve according to the HHP service requirements including the care manager ratio and the extent the CB-CME is able to satisfy all care team requirements. The count is taken at a point in time, which will be the last day of the quarter.
5. Health Home Program Annual CMS Core Measures Reporting	

DHCS is required to collect and report the Core Set of Health Care Quality Measures for Medicaid Health Homes Programs according to the Technical Specifications published by CMS. DHCS will continue to make the annual Technical Specification link available to the MCPs. MCPs are required to follow the technical specifications. DHCS will use the reporting template to collect measure information from the MCPs so that DHCS can perform the aggregation, weighting, and reporting required by the Technical Specifications. For additional information on the Core Measures, refer to the Technical Specifications and Resource Manual link from CMS. Approve the license agreements and download the Technical Specifications.

https://www.medicaid.gov/license-agreement.html?file=%2Fstate-resource-center%2Fmedicaid-state-technical-assistance%2Fhealth-home-information-resource-center%2Fdownloads%2FFFY-18-HH-Core-Set-Manual.pdf

Each MCP will determine its numerator, denominator, and/or rates for the required performance measure and report these results for each county. DHCS is required to report separately for each SPA, therefore, there are separate numerator, denominator, and rates columns for Chronic Conditions and SMI. The Technical Specifications measurement year and reporting year definitions are consistent with DHCS's other HEDIS oriented timelines. The Technical Specifications require reporting results when the SPA is in effect for six or more months of the measurement period. The fields in the template will be adjusted over time to align with the Technical Specifications if/when they change.

Note: **This tab is to be submitted annually in the Q1 report (due 5/31) of every year and include data on the previous calendar year of January through December.**

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year for the data reported: Year.
Controlling high blood pressure (CBP) (Med) age 18-59 w/HTN, BP < 140/90 - numerator (Column C)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (Med) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column D)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column E)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator

CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column F)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column G)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column H)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column I)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column J)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column K)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column L)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - numerator (Column M)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column N)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column O)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column P)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column Q)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column R)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column S)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column T)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column U)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator

CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column V)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CDF (MED) - Age 12-17 - numerator (Column W)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - numerator
CDF (MED) - Age 12-17 - denominator (Column X)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - denominator
CDF (MED) - Age 18-64 - numerator (Column Y)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - numerator
CDF (MED) - Age 18-64 - denominator (Column Z)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - denominator
CDF (MED) - Age 65+ - numerator (Column AA)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - numerator
CDF (MED) - Age 65+ - denominator (Column AB)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - denominator
CDF (SMI) - Age 12-17 - numerator (Column AC)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - numerator
CDF (SMI) - Age 12-17 - denominator (Column AD)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - denominator
CDF (SMI) - Age 18-64 - numerator (Column AE)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - numerator
CDF (SMI) - Age 18-64 - denominator (Column AF)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - denominator
CDF (SMI) - Age 65+ - numerator (Column AG)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - numerator
CDF (SMI) - Age 65+ - denominator (Column AH)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - denominator
6. Health Home Program Reporting Comments	
Column Name	**Explanation**
Comments (Column A)	Enter any relevant information pertaining to the submitted report and the data it contains.

H. Appendix H – HHP Eligible Condition Diagnosis Codes

HHP Eligible Condition Diagnosis Codes

Asthma
J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998
CAD
I20.0, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.710, I25.720, I25.730, I25.750, I25.751, I25.758, I25.759, I25.760, I25.790, I25.811, I25.82, I25.83, I25.84, I25.89, I25.9, Z95.1, Z95.5, Z98.61
CHF
I09.81, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
COPD
J41.0, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9
Dementia
F01.50, F01.51, F02.80, F0281, F03.90, F03.91, F04, F05, F06.8, F07.0 , F07.81 , F07.89, F09 , F48.2, G30.9 , G31.01, G31.09 , G31.1 , G31.83 , R41.81
Diabetes
E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, R81, Z46.81, R82.4 Z96.41

HHP Eligible Condition Diagnosis Codes

Hypertension
I10, I67.4, I11.9, I11.0, I12.9, I12.0, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, I15.2, I15.8, I15.9, N26.2,
Liver Disease
K72.00, K74.0, K74.60, K74.69, K74.3, K74.4, K74.5, K75.81, K76.0, K76.89, K74.1, K74.2, K76.9, K75.0, K75.1, K70.41, K71.11, K72.01, K72.90, K72.91, K76.6, K76.7, K72.10, K72.11, K76.1, K76.3, K76.5, K76.81, K77, R17, R18.8, Z48.23, Z94.4
TBI
S01.90XA, S01.90XD, S04.011S, S04.012S, S04.019S, S04.02XS, S04.031S, S04.032S, S04.039S, S04.041S, S04.042S, S04.049S, S04.10XS, S04.11XS, S04.12XS, S04.20XS, S04.21XS, S04.22XS, S04.30XS, S04.31XS, S04.32XS, S04.40XS, S04.41XS, S04.42XS, S04.50XS, S04.51XS, S04.52XS, S04.60XS, S04.61XS, S04.62XS, S04.70XS, S04.71XS, S04.72XS, S04.811S, S04.812S, S04.819S, S04.891S, S04.892S, S04.899S, S06.0X0A, S06.0X0D, S06.0X0S, S06.0X1A, S06.0X1D, S06.0X1S, S06.0X2A, S06.0X2D, S06.0X2S, S06.0X3A, S06.0X3D, S06.0X3S, S06.0X4A, S06.0X4D, S06.0X4S, S06.0X5A, S06.0X5D, S06.0X5S, S06.0X6A, S06.0X6D, S06.0X6S, S06.0X7A, S06.0X7D, S06.0X7S, S06.0X8A, S06.0X8D, S06.0X8S, S06.0X9A, S06.0X9D, S06.0X9S, S06.1X0A, S06.1X0D, S06.1X0S, S06.1X1A, S06.1X1D, S06.1X1S, S06.1X2A, S06.1X2D, S06.1X2S, S06.1X3A, S06.1X3D, S06.1X3S, S06.1X4A, S06.1X4D, S06.1X4S, S06.1X5A, S06.1X5D, S06.1X5S, S06.1X6A, S06.1X6D, S06.1X6S, S06.1X7A, S06.1X7D, S06.1X7S, S06.1X8A, S06.1X8D, S06.1X8S, S06.1X9A, S06.1X9D, S06.1X9S, S06.2X0A, S06.2X0D, S06.2X0S, S06.2X1A, S06.2X1D, S06.2X1S, S06.2X2A, S06.2X2D, S06.2X2S, S06.2X3A, S06.2X3D, S06.2X3S, S06.2X4A, S06.2X4D, S06.2X4S, S06.2X5A, S06.2X5D, S06.2X5S, S06.2X6A, S06.2X6D, S06.2X6S, S06.2X7A, S06.2X7D, S06.2X7S, S06.2X8A, S06.2X8D, S06.2X8S, S06.2X9A, S06.2X9D, S06.2X9S, S06.300A, S06.300D, S06.300S, S06.301A, S06.301D, S06.301S, S06.302A, S06.302D, S06.302S, S06.303A, S06.303D, S06.303S, S06.304A, S06.304D, S06.304S, S06.305A, S06.305D, S06.305S, S06.306A, S06.306D, S06.306S, S06.307A, S06.307D, S06.307S, S06.308A, S06.308D, S06.308S, S06.309A, S06.309D, S06.309S, S06.310A, S06.310D, S06.310S, S06.311A, S06.311D, S06.311S, S06.312A, S06.312D, S06.312S, S06.313A, S06.313D, S06.313S, S06.314A, S06.314D, S06.314S, S06.315A, S06.315D, S06.315S, S06.316A, S06.316D, S06.316S, S06.317A, S06.317D, S06.317S, S06.318A, S06.318D, S06.318S, S06.319A, S06.319D, S06.319S, S06.320A, S06.320D, S06.320S, S06.321A, S06.321D, S06.321S, S06.322A, S06.322D, S06.322S, S06.323A, S06.323D, S06.323S, S06.324A, S06.324D, S06.324S, S06.325A, S06.325D, S06.325S, S06.326A, S06.326D, S06.326S, S06.327A, S06.327D, S06.327S, S06.328A, S06.328D, S06.328S, S06.329A, S06.329D, S06.329S, S06.330A, S06.330D, S06.330S, S06.331A, S06.331D, S06.331S, S06.332A, S06.332D, S06.332S, S06.333A, S06.333D, S06.333S, S06.334A, S06.334D, S06.334S, S06.335A, S06.335D, S06.335S, S06.336A, S06.336D, S06.336S, S06.337A, S06.337D, S06.337S, S06.338A, S06.338D, S06.338S, S06.339A, S06.339D, S06.339S, S06.340A, S06.340D, S06.340S, S06.341A, S06.341D, S06.341S, S06.342A, S06.342D, S06.342S, S06.343A, S06.343D, S06.343S, S06.344A, S06.344D, S06.344S, S06.345A, S06.345D, S06.345S, S06.346A, S06.346D,

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Bipolar Disorder
F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
Major Depressive Disorder
F06.30, F06.31, F06.32, F06.33, F06.34, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39
Psychotic Disorders
F06.0, F06.2, F20.0, F20.1, F20.2, F20.3 , F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F44.89
Alcohol Related
F10.121, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250,

F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.921, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, G62.1, I42.6, K29.20, K29.21, K70.0, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.9
Substance Related
F11.121, F11.122, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.920, F12.921, F12.922, F12.929, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.920, F14.921, F14.922, F14.929, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.21, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.121, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.21, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.920, F19.921, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, T40.0X1A, T40.0X1D, T40.0X2A, T40.0X2D, T40.0X3A, T40.0X3D, T40.0X4A, T40.0X4D, T40.1X1A, T40.1X1D, T40.1X2A, T40.1X2D, T40.1X3A, T40.1X3D, T40.1X4A, T40.1X4D, T40.2X1A, T40.2X1D, T40.2X2A, T40.2X2D, T40.2X3A, T40.2X3D, T40.2X4A, T40.2X4D, T40.3X1A, T40.3X1D, T40.3X2A, T40.3X2D, T40.3X3A, T40.3X3D, T40.3X4A, T40.3X4D, T40.4X1A, T40.4X1D,

T40.4X2A, T40.4X2D, T40.4X3A, T40.4X3D, T40.4X4A, T40.4X4D, T40.601A, T40.601D, T40.602A, T40.602D, T40.603A, T40.603D, T40.604A, T40.604D, T40.691A, T40.691D, T40.692A, T40.692D, T40.693A, T40.693D, T40.694A, T40.694D
Kidney Disease
N18.1, N18.2, N18.3 , N18.4 , N18.5, N18.6, N18.9, Z48.22, Z49.01 , Z49.02, Z49.31 , Z49.32, Z91.15 , Z94.0

I. Appendix I – HHP Implementation Schedule

HHP Implementation Schedule

The California Department of Health Care Services (DHCS) announced that the implementation of the state's Health Homes Program (HHP) begins July 1, 2018. The counties included in each group and the phased implementation schedule are outlined in the table below:

County Implementation Schedule

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders	(Phase 2) Implementation date for members with eligible serious mental illness conditions
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Imperial • Kern • Los Angeles • Sacramento • San Diego • Santa Clara • Tulare	July 1, 2019	January 1, 2020
Group 4	• Orange	January 1, 2020	July 1, 2020

J. Appendix J – HHP Supplemental Payment File

Please refer to the DHCS' *Technical Guidance – Consolidated Supplemental Upload Process for further information.*

K. Appendix K – Whole Person Care Pilot Interaction Guidance

Joint Medi-Cal Managed Care Health Plan and Whole Person Care Pilot Guidance:

Eligibility and Provision of Services in the Health Homes Program and

Whole Person Care Pilots

This notification provides DHCS policy guidance regarding the eligibility, enrollment and the provision of services for Medi-Cal beneficiaries concurrently eligible for both the Health Homes Program (HHP) and a Whole Person Care (WPC) Pilot.

Medi-Cal managed care health plans (MCPs) implementing the HHP are responsible for providing the following six core HHP services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria.

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots are administered at the local level where a county, a city and county, a health or hospital authority, or a consortium of any of the above can serve as the Lead Entity (LE). WPC eligibility is established by each Pilot.

DHCS' guidance is that Medi-Cal beneficiaries that are eligible to receive services from both the WPC Pilot program and the HHP can be enrolled in either program or both, based on beneficiary choice.

In most cases WPC pilots provide care coordination services that are similar to the care coordination services provided by the HHP program. If a Medi-Cal beneficiary is eligible for both WPC and HHP, the member may choose which program's care coordination services that want to receive. The member may not receive duplicative care coordination services from both WPC and HHP. If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC. The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

If the beneficiary chooses to receive care coordination services through WPC and is also interested in participating in the HHP, the beneficiary will not be able to receive any HHP services due to HHP, by default, being a program that consists of a set of 6 care-coordination services that are offered as the core benefit of the program.

In most cases WPC pilots also provide other services that are not duplicative, or similar to, HHP care coordination services. A sobering center service is one example of a WPC service that is likely to not be duplicative of HHP services. If a member is eligible for both WPC and HHP, and the member chooses to receive care coordination services through the HHP, the member may still receive other WPC services (that are not duplicative of HHP services) through the WPC. The WPC pilot may claim reimbursement for these other services regardless of whether the beneficiary chooses to receive care coordination services through the WPC or the HHP.

Please see the following points regarding DHCS' expectations:

- All WPC LEs must ensure the non-duplication of services for their WPC-enrolled members.

- The LEs are required to check other program participation, including HHP, as a regular part of their assessments. DHCS recommends frequent communication between the LE and their local MCPs to ensure there is no duplication of services.

- The WPC "Certification of Lead Entity Reports" document has been revised to include an additional attestation stating that DHCS reserves the right to recoup payments made to LEs for services found to be duplicative.

- LEs are responsible for keeping auditable records, such as documentation of their in-person assessments of enrollee participation in other programs, which should address non-duplication of services.

- As always, DHCS reserves the right to perform an audit of LE data and MCP data.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Ratification of Amendments to Medi-Cal Health Network Contracts, Excluding Those Involving the CHOC Physicians Network

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Ratify Medi-Cal health network contract amendments, excluding those involving the CHOC Physicians Network, to address continued payments to individual providers of Proposition 56 appropriated funds and to compensate the health networks an administrative fee for performance of these responsibilities for services began in State Fiscal Year (SFY) 2018-19 and all future extensions thereafter provided the State of California continues the enhanced Proposition 56 payments to CalOptima.

Background/Discussion

Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through either direct communication or an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance and rates are not provided until after the fiscal year begins; requiring MCPs to develop initial catch up and ongoing payment distribution processes.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. On November 1, 2018 the Board authorized contract amendments to Medi-Cal health network contracts to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance had not been released as of May 8, 2019. Even though the final APL for the current fiscal year had not been released, DHCS instructed MCPs to distribute initial catch up SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019. In a separate Board action, CalOptima staff requested approval of a standardized annual Proposition 56 provider payment process.

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The standardized annual Proposition 56 provider payment process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. To continue Proposition 56 provider payments, Staff amended health network contracts to the extend the dates of service eligible for Proposition 56 payments into the current SFY and to ensure payments are made within with the timeframes based on DHCS guidance. CalOptima staff will seek subsequent Board action for further action if any future DHCS Proposition 56 requirements warrant significant changes to the standardized annual process.

Fiscal Impact

The recommended action to ratify amendments to Medi-Cal health network contracts, excluding those involving the CHOC Physicians Network, related to Proposition 56 is projected to be budget neutral to CalOptima. While total disbursement of Proposition 56 funding is dependent upon timely and accurate claims submissions from eligible providers, DHCS has projected Fiscal Year 2018-19 funding at approximately $102 million. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation

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

Concurrence

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

Attachments

1. Conflicts of Interest List: Medi-Cal Health Networks
2. June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment
3. November 1, 2018 CalOptima Board Action Agenda Referral 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

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

6/20/2019 — **Date**

Conflicts of Interest List: Medi-Cal Health Networks

Name	Address	City	State	Zip Code
AltaMed Health Services	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CHOC Health Alliance	1120 West La Veta Ave., #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868

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.

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

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

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

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken 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

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**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

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

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

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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 June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

25. Consider Authorizing Amended and Restated Medi-Cal Health Network Contract for Kaiser Foundation Health Plan, Inc to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an Amended and Restated Health Network Contract with Kaiser Foundation Health Plan, Inc., effective June 30, 2019 that address the following:

a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements; and
b) Amended capitation rates for assigned members effective July 1, 2019.

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid Managed Care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to: emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

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Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

The anticipated Medi-Cal revenue for FY 2019-20 is projected to be sufficient to cover the costs of the recommended action to amend capitation rates for assigned members effective July 1, 2019. Management has included projected expenses associated with the extended contracts in the proposed CalOptima FY 2019-20 Operating Budget pending Board approval.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

/s/ Michael Schrader — *5/29/2019*

Authorized Signature — **Date**

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

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Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

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[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

ALL PLAN LETTER 19-001
Attachment A

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

Rev. 6/7/2018

        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

CalOptima
A Public Agency
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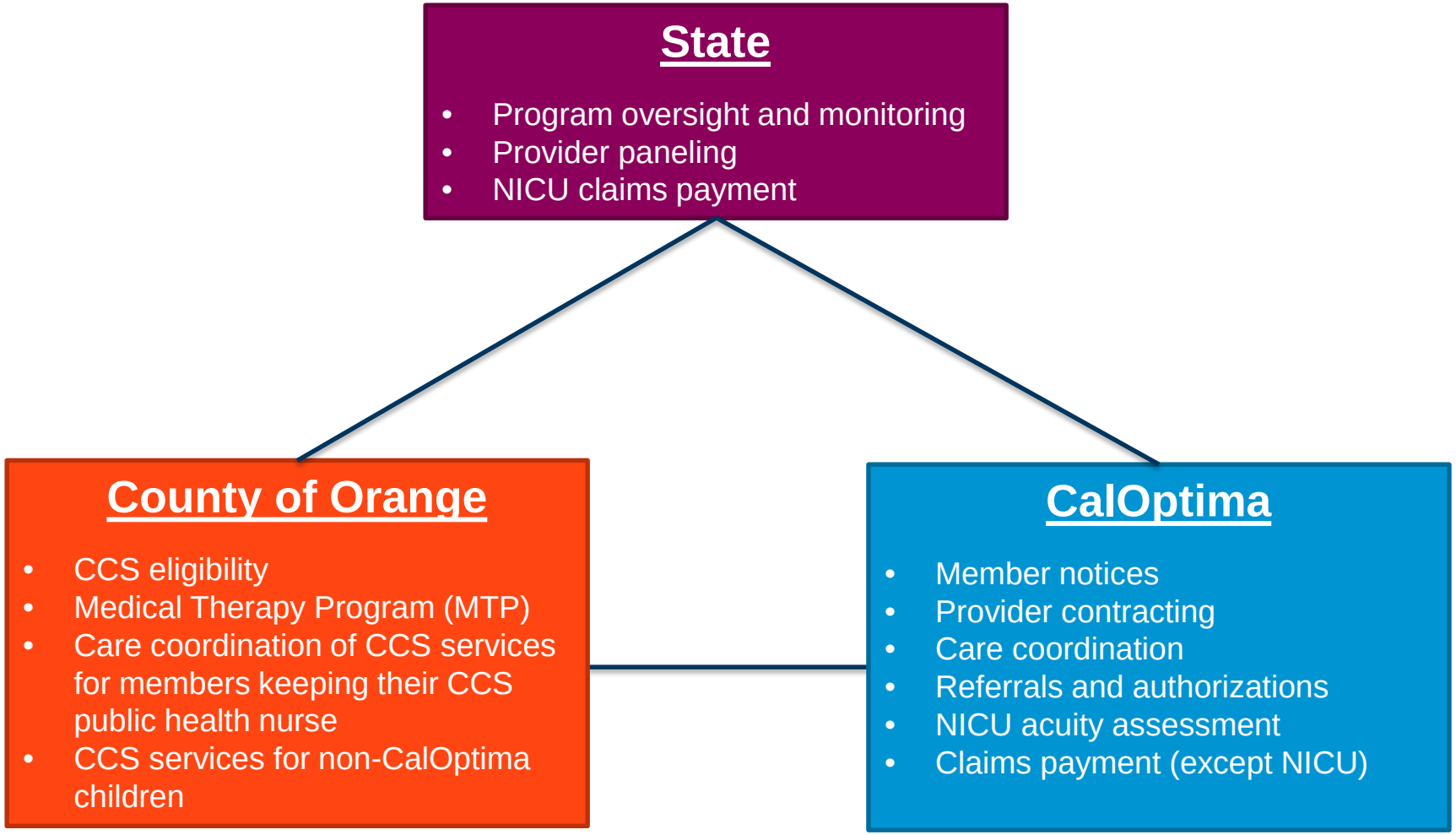
Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

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

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature _____ **Date** _____

Print Name _____

CalOptima
A Public Agency
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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

16. Consider Authorizing Extension of Federal Legislative Advocacy Services Contract with Akin Gump Straus Hauer & Feld LLP

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Action

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute an amendment to extend the contract of Akin Gump Straus Hauer & Feld LLP for federal legislative advocacy services for one month, commencing February 21, 2021.

Background

As part of its Government Affairs program, and in addition to work with various trade associations, CalOptima retains representation in Washington D.C. to assist in a wide array of areas, including tracking legislation, developing and maintaining relationships with the administration and applicable federal departments and regulatory agencies, members of Congress, legislative committee staff and consultants, and providing analysis and recommended actions pertaining to the federal budget.

Akin Gump Straus Hauer & Feld LLP (Akin Gump) currently provides CalOptima with federal advocacy services. On February 2, 2017, the Board authorized a contract with Akin Gump for a three-year term, commencing on February 21, 2017, with two one-year options, each exercisable at CalOptima's sole discretion. CalOptima Board of Directors authorized execution of the first of the two one-year extension options on February 6, 2020. CalOptima's current contract with Akin Gump expires on February 20, 2021.

Consistent with CalOptima's procurement processes, a Request for Proposal (RFP) for federal legislative advocacy services was issued on December 8, 2020, and a total of four (4) proposals were received. Evaluation and interviews are currently being conducted by CalOptima staff, external subject matter experts and a Board ad hoc committee.

Discussion

Following the recommendations of the Board ad hoc committee, staff expects to bring an agenda item for federal advocacy services to the March 4, 2021, meeting for Board consideration. As such, a new contract will not be executed prior to the end of Akin Gump's current contract term on February 20, 2021.

As proposed, in order to ensure that CalOptima has uninterrupted representation in Washington, D.C., the recommended action is to authorize the extension under the existing terms and conditions of Akin Gump's contract term for one additional month, ending on March 20, 2021, which requires the execution of an amendment to the current contract at $10,000 per month. The fee includes phone, fax, in-office copying, regular postage, and printing. Any out of the ordinary expenses, such as airline travel, will be

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incurred only if authorized in advance by CalOptima.

Fiscal Impact

The recommended action extends the contract, under the same terms and conditions, with Akin Gump Straus Hauer & Feld LLP for federal legislative advocacy services for the period of February 21, 2021, through March 20, 2021. Associated funding for federal legislative advocacy services for this period is budgeted under the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

Federal legislative advocacy efforts continue to be a priority for CalOptima given the level of activity on health care issues in Washington, D.C. CalOptima staff anticipates that several important issues will require focus, attention, involvement, and advocacy in the coming weeks while staff and the Board ad hoc committee continue to evaluate federal advocacy firms, based on the RFP process.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 2, 2017, Consider Authorizing Selection and Contracting for Federal Legislative Advocacy Services
2. Board Action dated February 6, 2020, Consider Authorizing Selection and Contracting for Federal Legislative Advocacy Services

/s/ Richard Sanchez — *01/27/2021*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Selection and Contracting with Vendor for Federal Legislative Advocacy Services

Contact
Phil Tsunoda, Executive Director, Public Affairs and Public Policy, (714) 246-8400

Recommended Actions
1. Approve recommend federal advocacy firm Akin Gump Strauss Hauer & Feld LLP to represent CalOptima for federal regulatory and advocacy services;
2. Authorize the Chief Executive Officer to execute applicable contract with the recommended firm;
3. Authorize expenditures of up to $32,000 from existing reserves for the additional costs in excess of the budget for federal legislative advocacy services for FY2016-17, to deliver all services detailed in the Request for Proposal (RFP) Statement of Work, with total expenditures not to exceed $10,000 per month.

Background
As part of its Government Affairs program, CalOptima retains representatives in Washington D.C. to assist in a wide array of areas, including tracking legislation, developing and maintaining relationships with the administration and applicable federal departments and regulatory agencies, members of Congress, legislative committee staff and consultants, and providing analysis and recommended actions pertaining to the federal budget.

CalOptima's contract with its current federal advocacy services firm was set to expire on January 7, 2017. On December 1, 2016, the Board authorized an extension of CalOptima's contract with CalOptima's current federal advocacy services firm for six (6) additional months, to allow time for the Board Ad Hoc and staff to recommend a federal advocacy firm to the full Board.

A Request for Proposal (RFP) for federal advocacy services was issued by CalOptima on September 8, 2016 and a total of six (6) proposals were received. An evaluation committee comprised of staff and two external stakeholder representatives reviewed the submitted proposals. Four of the firms were recommended for interviews before the Federal Advocacy RFP Ad Hoc evaluation committee of Supervisor Lisa Bartlett, Director Ron DiLuigi, Supervisor Andrew Do and Director Nikan Khatibi. After evaluation of proposals and in-person interviews conducted by the Board Ad Hoc, two top finalists were identified. Based on the "best and final offer" received by the two finalists, the Board Ad Hoc recommends Akin Gump Strauss Hauer & Feld LLP to provide federal legislative advocacy services for CalOptima. The RFP scope of work and score sheet summaries for the firms responding to the RFP are attached.

Discussion
The Board Ad Hoc is recommending Akin Gump Strauss Hauer & Feld LLP due to their proposal and represented grasp of the issues within the healthcare field. These issues included, but are not limited to, CalOptima specifically, and County Organized Health Systems (COHS) generally, the future

potential changes regarding Affordable Care Act (ACA), and, future potential changes regarding Medicaid and Medicare.

Staff and the Ad Hoc believe Akin Gump will provide added value in the Agency's advocacy efforts. It was concluded that the firm has broad healthcare experience, a depth of resources and strong connections with key influencers within the healthcare field and the current administration that could be very beneficial to CalOptima as compared to the other proposals.

Staff will review the performance of the Akin Gump contract to ensure that the deliverables are being achieved. In addition to its monthly written report, it is anticipated that Akin Gump will present occasional verbal updates at the request of the Board or staff, at monthly Board of Directors' meetings.

Akin Gump Strauss Hauer & Feld LLP is also well established with the federal health industry associations that CalOptima works with.

The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $6,000 per month for federal advocacy services. Pursuant to the submitted proposal, Akin Gump Strauss Hauer & Feld LLP's proposed contract is priced at $10,000 per month beginning February 2017. Staff recommends Board authorization for up to $32,000 in expenditures from existing reserves for the additional costs above the budget for federal legislative advocacy services for FY 2016-17, as well as up to a two-month overlap (i.e., February and March 2017) between the current contract and future contract.

Fiscal Impact

The recommended action to authorize the expenditure of up to an additional $32,000 for federal legislative advocacy services through June 30, 2017, is unbudgeted. An allocation of $32,000 from existing reserves will fund this action to supplement the current Board approved budget. If the recommended vendor is approved, Staff will increase the projected federal legislative advocacy service expenses in the FY 2017-18 CalOptima Operating Budget.

Rationale for Recommendation

Federal advocacy efforts continue to be of importance to CalOptima given the stated health care-related priorities of the new presidential administration and congressional majority. There will be a number of important issues that require CalOptima's ongoing focus, including federal financing of the Medi-Cal program (including Medi-Cal expansion), reauthorization of the Children's Health Insurance Program (CHIP), and other issues related to the ACA.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Advocacy Services RFP Scoring Sheet
2. Federal Advocacy Services Scope of Work

/s/ Michael Schrader — *01/26/2017*

Authorized Signature — **Date**

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Summary

Federal Advocacy RFP 17-006

Firm Evaluation Scores

All firms were evaluated on a five point scale, 0-5.

	Proposal (25% of the overall score)	Interview (75% of the overall score)	Final Score
Akin Gump	3.60 x .25 = **0.90**	4.41 x .75 = **3.31**	**4.21* Recommended firm**
Potomac Partners DC	3.90 x .25 = **0.98**	4.41 x .75 = **3.31**	**4.29***
James F. McConnell	4.11 x .25 = **1.03**	3.33 x .75 = **2.38**	**3.40**
Waterman & Associates	3.29 x .25 = **0.82**	3.17 x .75 = **2.50**	**3.32**
Van Scoyoc Associates	3.22 x .25 = **0.81**		
Avancer Health Policy	2.70 x .25 = **0.68**		

*Submitted best and final offer

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Interview Evaluation

(75% of the overall score)

Finalist interviews were evaluated on a five point scale, 0-5.

	Presentations	Q&A	Overall Impression	Interview Total
Akin Gump	4.50 x .33 = **1.50**	4.50 x .33 = **1.50**	4.25 x .33 = **1.42**	**4.41**
Potomac Partners DC	4.50 x .33 = **1.50**	4.00 x .33 = **1.33**	4.75 x .33 = **1.58**	**4.41**
Waterman & Associates	3.00 x .33 = **1.00**	3.25 x .33 = **1.08**	3.75 x .33 = **1.25**	**3.33**
James F. McConnell	3.50 x .33 = **1.17**	3.00 x .33 = **1.00**	3.00 x .33 = **1.00**	**3.17**

Proposal Evaluation

(25% of the overall score)

Proposals were evaluated on a five point scale, 0-5. Weighted scores are listed below.

	Experience (40% of overall score)	Pricing (10%)	Advocacy Plan (40%)	Organization (10%)	Grand Total (100%)
James F. McConnell	4.2 x .40 = **1.68**	4.5 x .10 = **0.45**	4.0 x .40 = **1.60**	3.8 x .10 = 0.38	**4.11**
Potomac Partners DC	3.9 x .40 = **1.56**	3.7 x .10 = **0.37**	3.8 x .40 = **1.52**	4.5 x .10 = 0.45	**3.90**
Akin Gump	3.8 x .40 = **1.52**	2.1 x .10 = **0.21**	3.7 x .40 = **1.48**	3.9 x .10 = 0.39	**3.60**
Waterman & Associates	3.3 x .40 = **1.32**	3.7 x .10 = **0.37**	3.2 x .40 = **1.28**	3.2 x .10 = 0.32	**3.29**
Van Scoyoc Associates	3.0 x .40 = **1.20**	2.2 x .10 = **0.22**	3.6 x .40 = **1.44**	3.6 x .10 = 0.36	**3.22**
Avancer Health Policy	3.1 x .40 = **1.24**	4.4 x .10 = **0.44**	2.0 x .40 = **0.80**	2.2 x .10 = 0.22	**2.70**

The top four firms advanced to the interview phase.

A. Scope of Work

I. PURPOSE

CONSULTANT shall represent CalOptima's interests in Washington, D.C., and have the responsibility of monitoring and influencing legislative and regulatory policies, building and maintaining positive, mutually beneficial relationships, and providing CalOptima with necessary advocacy services.

II. REPORTING RELATIONSHIP

CalOptima Government Affairs leadership staff will be the primary CalOptima contacts and will direct the work of the CONSULTANT. All work determined to be in excess of the work specified herein will be approved by the primary contacts in conjunction with the CalOptima Vendor Management staff who shall then prepare an amendment to the Contract.

III. OBJECTIVE/DELIVERBLES

CONSULTANT shall:

1. Maintain regular contact with the Administration, members of Congress, specifically the Orange County congressional delegation, legislative staff, and committee staff to identify impending changes in laws, new program opportunities, and funding priorities that relate to CalOptima. When directed by CalOptima, the CONSULTANT shall also communicate with federal departments, agencies, boards, committees, committees and staff regarding identified issues.

2. As directed by CalOptima, brief Orange County congressional delegation with CalOptima updates, publications and other informational items. These may include the annual Report to the Community, Fast Facts, and other materials.

3. Arrange meetings and briefings for CalOptima Board and staff with elected officials and legislative staff. The CONSULTANT shall be proactive in scheduling strategic, targeted meetings and briefings especially, but not limited to, times when CalOptima Board and staff are scheduled to be in Washington, D.C. Meetings and briefings may include formal briefings, as well as informal social meetings, as appropriate.

4. Provide monthly, written reports which shall include a federal budget and legislative update, as well as a description of the nature and extent of services or actions taken on behalf of CalOptima. The services and actions shall include a summary of the meetings the CONSULTANT had along with the issues discussed with members of Congress, specifically the Orange County congressional delegation, legislative staff, relevant committee staff as well as appropriate departments, agencies, boards, and commissions, committees, and staff. The reports shall be delivered on a schedule as directed by CalOptima staff, and may be included in the CalOptima board book and/or provided to board members.

5. Provide in-person briefings, as directed by CalOptima staff, to the CalOptima board and executive staff.

6. Notify CalOptima of anticipated, introduced or amended federal legislation, and proposed regulations which could impact CalOptima. These activities include, but are not limited to:
   - Providing the bill number and brief summary of introduced or amended federal legislation;
   - Providing copies of legislation and committee analysis; and
   - Providing information relative to legislative hearings

Advocate for CalOptima's programs and positions regarding proposed legislation, proposed regulations, and funding priorities as directed.

Provide copies of all written correspondence, testimony, and position papers given on behalf of CalOptima, as well as access to the federal budget and any related documents (Congressional Budget Office analysis, etc.) as they become available.

CalOptima staff may prepare a formal annual review of CONSULTANT's work product at the end of each calendar year.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
9. Consider Authorizing Extension of Federal Legislative Advocacy Services Contract with Akin Gump Straus Hauer & Feld LLP

Contact
Silver Ho, Executive Director, Compliance, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to exercise the option to extend the contract of Akin Gump Straus Hauer & Feld LLP for federal legislative advocacy services for one year, per the terms of the current contract, commencing February 21, 2020.

Background
As part of its Government Affairs program, CalOptima retains representatives in Washington D.C. to assist in a wide array of areas, including tracking legislation, developing and maintaining relationships with the administration and applicable federal departments and regulatory agencies, members of Congress, legislative committee staff and consultants, and providing analysis and recommended actions pertaining to the federal budget.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for federal legislative advocacy services was issued on September 8, 2016 and a total of six (6) proposals were received. Subsequently, evaluation and interviews were conducted by CalOptima staff, external subject matter experts and a Board ad hoc committee, which recommended Akin Gump Straus Hauer & Feld LLP (Akin Gump). On February 2, 2017, the Board authorized the Chief Executive Officer to contract with Akin Gump for a three-year term, commencing on February 21, 2017, with two one-year options, each exercisable at CalOptima's sole discretion. Akin Gump's current contract term ends on February 20, 2020.

Discussion
Akin Gump has substantial knowledge and experience in health care issues important to CalOptima. The firm is also well established with the federal health industry associations with which CalOptima works. In addition to its monthly written report, Akin Gump has presented verbal updates at the request of staff, most recently at the December 2, 2019 Board of Directors' meeting.

As proposed, the recommended action is to extend Akin Gump's contract for an additional one-year term, per the option exercisable at CalOptima's discretion under the current contract. Akin Gump's contract fee is $10,000 per month. The fee includes phone, fax, in-office copying, regular postage, and printing. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.

Consistent with CalOptima's practice, staff will monitor the performance of Akin Gump to ensure that the deliverables and components outlined in the contract are being achieved. Deliverables include, but

are not limited to, written and verbal monthly reports, updates and discussions with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

Fiscal Impact

The recommended action extends the contract with Akin Gump Straus Hauer & Feld LLP for federal legislative advocacy services from February 21, 2020 through February 20, 2021. Associated expenses for February 21, 2020 through June 30, 2020 are budgeted for under the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Management will include funding for the period of July 1, 2020 through February 20, 2021, in the CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation

Federal legislative advocacy efforts continue to be a priority for CalOptima given the level of activity on health care issues in Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy in the coming year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 2, 2017, Consider Authorizing Selection and Contracting for Federal Legislative Advocacy Services

/s/ Michael Schrader *01/28/2020*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Selection and Contracting with Vendor for Federal Legislative Advocacy Services

Contact
Phil Tsunoda, Executive Director, Public Affairs and Public Policy, (714) 246-8400

Recommended Actions
1. Approve recommend federal advocacy firm Akin Gump Strauss Hauer & Feld LLP to represent CalOptima for federal regulatory and advocacy services;
2. Authorize the Chief Executive Officer to execute applicable contract with the recommended firm;
3. Authorize expenditures of up to $32,000 from existing reserves for the additional costs in excess of the budget for federal legislative advocacy services for FY2016-17, to deliver all services detailed in the Request for Proposal (RFP) Statement of Work, with total expenditures not to exceed $10,000 per month.

Background
As part of its Government Affairs program, CalOptima retains representatives in Washington D.C. to assist in a wide array of areas, including tracking legislation, developing and maintaining relationships with the administration and applicable federal departments and regulatory agencies, members of Congress, legislative committee staff and consultants, and providing analysis and recommended actions pertaining to the federal budget.

CalOptima's contract with its current federal advocacy services firm was set to expire on January 7, 2017. On December 1, 2016, the Board authorized an extension of CalOptima's contract with CalOptima's current federal advocacy services firm for six (6) additional months, to allow time for the Board Ad Hoc and staff to recommend a federal advocacy firm to the full Board.

A Request for Proposal (RFP) for federal advocacy services was issued by CalOptima on September 8, 2016 and a total of six (6) proposals were received. An evaluation committee comprised of staff and two external stakeholder representatives reviewed the submitted proposals. Four of the firms were recommended for interviews before the Federal Advocacy RFP Ad Hoc evaluation committee of Supervisor Lisa Bartlett, Director Ron DiLuigi, Supervisor Andrew Do and Director Nikan Khatibi. After evaluation of proposals and in-person interviews conducted by the Board Ad Hoc, two top finalists were identified. Based on the "best and final offer" received by the two finalists, the Board Ad Hoc recommends Akin Gump Strauss Hauer & Feld LLP to provide federal legislative advocacy services for CalOptima. The RFP scope of work and score sheet summaries for the firms responding to the RFP are attached.

Discussion
The Board Ad Hoc is recommending Akin Gump Strauss Hauer & Feld LLP due to their proposal and represented grasp of the issues within the healthcare field. These issues included, but are not limited to, CalOptima specifically, and County Organized Health Systems (COHS) generally, the future

potential changes regarding Affordable Care Act (ACA), and, future potential changes regarding Medicaid and Medicare.

Staff and the Ad Hoc believe Akin Gump will provide added value in the Agency's advocacy efforts. It was concluded that the firm has broad healthcare experience, a depth of resources and strong connections with key influencers within the healthcare field and the current administration that could be very beneficial to CalOptima as compared to the other proposals.

Staff will review the performance of the Akin Gump contract to ensure that the deliverables are being achieved. In addition to its monthly written report, it is anticipated that Akin Gump will present occasional verbal updates at the request of the Board or staff, at monthly Board of Directors' meetings.

Akin Gump Strauss Hauer & Feld LLP is also well established with the federal health industry associations that CalOptima works with.

The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $6,000 per month for federal advocacy services. Pursuant to the submitted proposal, Akin Gump Strauss Hauer & Feld LLP's proposed contract is priced at $10,000 per month beginning February 2017. Staff recommends Board authorization for up to $32,000 in expenditures from existing reserves for the additional costs above the budget for federal legislative advocacy services for FY 2016-17, as well as up to a two-month overlap (i.e., February and March 2017) between the current contract and future contract.

Fiscal Impact

The recommended action to authorize the expenditure of up to an additional $32,000 for federal legislative advocacy services through June 30, 2017, is unbudgeted. An allocation of $32,000 from existing reserves will fund this action to supplement the current Board approved budget. If the recommended vendor is approved, Staff will increase the projected federal legislative advocacy service expenses in the FY 2017-18 CalOptima Operating Budget.

Rationale for Recommendation

Federal advocacy efforts continue to be of importance to CalOptima given the stated health care-related priorities of the new presidential administration and congressional majority. There will be a number of important issues that require CalOptima's ongoing focus, including federal financing of the Medi-Cal program (including Medi-Cal expansion), reauthorization of the Children's Health Insurance Program (CHIP), and other issues related to the ACA.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Advocacy Services RFP Scoring Sheet
2. Federal Advocacy Services Scope of Work

/s/ Michael Schrader — *01/26/2017*

Authorized Signature — **Date**

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Summary

Federal Advocacy RFP 17-006

Firm Evaluation Scores

All firms were evaluated on a five point scale, 0-5.

	Proposal (25% of the overall score)	Interview (75% of the overall score)	Final Score
Akin Gump	3.60 x .25 = **0.90**	4.41 x .75 = **3.31**	**4.21* Recommended firm**
Potomac Partners DC	3.90 x .25 = **0.98**	4.41 x .75 = **3.31**	**4.29***
James F. McConnell	4.11 x .25 = **1.03**	3.33 x .75 = **2.38**	**3.40**
Waterman & Associates	3.29 x .25 = **0.82**	3.17 x .75 = **2.50**	**3.32**
Van Scoyoc Associates	3.22 x .25 = **0.81**		
Avancer Health Policy	2.70 x .25 = **0.68**		

*Submitted best and final offer

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Interview Evaluation

(75% of the overall score)

Finalist interviews were evaluated on a five point scale, 0-5.

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CalOptima staff may prepare a formal annual review of CONSULTANT's work product at the end of each calendar year.

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Financial Summary

November 30, 2020

Board of Directors Meeting

February 4, 2021

Nancy Huang, Chief Financial Officer

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FY 2020–21: Management Summary

- Change in Net Assets (Deficit) or Surplus
  - MTD: $2.2 million, unfavorable to budget $1.0 million or 30.5%
  - YTD: $1.6 million, favorable to budget $5.3 million or 142.4%
- Enrollment
  - MTD: 801,270 members, favorable to budget 3,276 or 0.4%
  - YTD: 3,939,153 member months, favorable to budget 11,026 or 0.3%
- Revenue
  - MTD: $315.4 million, unfavorable to budget $9.1 million or 2.8% driven by Medi-Cal (MC) and OneCare Connect (OCC) line of businesses (LOB):
    - $4.1 million of Behavioral Health Treatment (BHT) revenue due to retroactive utilization report submitted by Kaiser.
    - $3.3 million of Proposition 56 risk corridor reserve
    - $4.0 million calendar year (CY) 2020 Quality Withhold (QW) accrual for OCC
    - Offset by $22.2 million due to updated guidance for Gross Medical Expenditures (GME) risk corridor reserve for global sub-capitation
  - YTD: $1.7 billion, favorable to budget $58.4 million or 3.6% driven by MC LOB:
    - Fiscal year (FY) 2019 hospital Directed Payments (DP)
    - Offset by bridge period GME reduction and Proposition 56 risk corridor reserve

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FY 2020–21: Management Summary (cont.)

- Medical Expenses
  - MTD: $302.9 million, favorable to budget $7.8 million or 2.5%
    - Driven by MC LOB $10.2 million favorable variance due to decreased utilization during COVID-19 pandemic
    - Offset by OCC LOB $2.5 million unfavorable variance
  - YTD: $1.6 billion, unfavorable to budget $56.7 million or 3.7%
    - Primarily driven by MC LOB FY 2019 hospital DP, offset by decreased utilization during COVID-19 pandemic
- Administrative Expenses
  - MTD: $11.0 million, favorable to budget $1.0 million or 8.0%
  - YTD: $55.4 million, favorable to budget $7.9 million or 12.6%
- Net Investment & Other Income
  - MTD: $0.6 million, unfavorable to budget $0.6 million or 51.3%
  - YTD: $2.0 million, unfavorable to budget $4.3 million or 68.6%

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FY 2020–21: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 96.0%, Budget 95.7%
  - YTD: Actual 96.7% (96.5% excluding DP), Budget 96.7%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 3.5%, Budget 3.7%
  - YTD: Actual 3.3% (3.5% excluding DP), Budget 3.9%
- Balance Sheet Ratios
  - Current ratio: 1.3
  - Board-designated reserve funds level: 1.95
  - Net position: $1.0 billion, including required Tangible Net Equity (TNE) of $102.5 million

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Enrollment Summary: November 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
113,720	110,934	2,786	2.5%	SPD	566,582	554,278	12,304	2.2%
500	477	23	4.8%	BCCTP	2,563	2,425	138	5.7%
292,943	311,636	(18,693)	(6.0%)	TANF Child	1,452,219	1,525,738	(73,519)	(4.8%)
99,872	93,695	6,177	6.6%	TANF Adult	486,192	458,958	27,234	5.9%
4,910	3,513	1,397	39.8%	LTC	24,305	17,545	6,760	38.5%
261,463	249,980	11,483	4.6%	MCE	1,267,731	1,230,178	37,553	3.1%
11,257	11,931	(674)	(5.6%)	WCM	56,902	59,659	(2,757)	(4.6%)
784,665	**782,166**	**2,499**	**0.3%**	**Medi-Cal Total**	**3,856,494**	**3,848,781**	**7,713**	**0.2%**
14,587	**14,027**	**560**	**4.0%**	**OneCare Connect**	**72,842**	**70,402**	**2,440**	**3.5%**
1,625	**1,378**	**247**	**17.9%**	**OneCare**	**7,894**	**6,890**	**1,004**	**14.6%**
393	**423**	**(30)**	**(7.1%)**	**PACE**	**1,923**	**2,054**	**(131)**	**(6.4%)**
801,270	**797,994**	**3,276**	**0.4%**	**CalOptima Total**	**3,939,153**	**3,928,127**	**11,026**	**0.3%**

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CalOptima
A Public Agency

Financial Highlights: November 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
801,270	797,994	3,276	0.4%	Member Months	3,939,153	3,928,127	11,026	0.3%
315,444,876	324,570,016	(9,125,140)	(2.8%)	Revenues	1,663,747,712	1,605,377,196	58,370,516	3.6%
302,852,074	310,689,111	7,837,038	2.5%	Medical Expenses	1,608,761,353	1,552,076,196	(56,685,157)	(3.7%)
10,976,837	11,930,552	953,715	8.0%	Administrative Expenses	55,355,217	63,304,156	7,948,939	12.6%
1,615,966	**1,950,353**	**(334,387)**	**(17.1%)**	**Operating Margin**	**(368,857)**	**(10,003,156)**	**9,634,299**	**96.3%**
608,750	1,250,000	(641,250)	(51.3%)	Non Operating Income (Loss)	1,961,363	6,250,000	(4,288,637)	(68.6%)
2,224,716	**3,200,353**	**(975,637)**	**(30.5%)**	**Change in Net Assets**	**1,592,506**	**(3,753,156)**	**5,345,662**	**142.4%**
96.0%	95.7%	(0.3%)		Medical Loss Ratio	96.7%	96.7%	(0.0%)	
3.5%	3.7%	0.2%		Administrative Loss Ratio	3.3%	3.9%	0.6%	
0.5%	0.6%	(0.1%)		Operating Margin Ratio	(0.0%)	(0.6%)	0.6%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
96.0%	95.7%	(0.3%)		*MLR (excluding Directed Payments)	96.5%	96.7%	0.2%	
3.5%	3.7%	0.2%		*ALR (excluding Directed Payments)	3.5%	3.9%	0.4%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(0.4)	2.3	(2.6)	Medi-Cal	(4.6)	(6.5)	1.9
1.2	(0.7)	1.9	OCC	0.7	(4.8)	5.4
(0.0)	0.1	(0.1)	OneCare	0.6	0.3	0.4
0.8	0.3	0.5	PACE	2.9	1.0	2.0
1.6	**2.0**	**(0.3)**	**Operating**	**(0.4)**	**(10.0)**	**9.6**
0.6	1.3	(0.6)	Inv./Rental Inc, MCO tax	2.0	6.3	(4.3)
0.6	**1.3**	**(0.6)**	**Non-Operating**	**2.0**	**6.3**	**(4.3)**
2.2	**3.2**	**(1.0)**	**TOTAL**	**1.6**	**(3.8)**	**5.3**

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Consolidated Revenue & Expenses: November 2020 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	511,945	261,463	11,257	784,665	14,587	1,625	393	801,270
REVENUES								
Capitation Revenue	152,045,323	$ 105,823,633	$ 22,248,895	$ 280,117,851	$ 30,038,045	$ 1,929,721	$ 3,359,260	$ 315,444,876
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	152,045,323	105,823,633	22,248,895	280,117,851	30,038,045	1,929,721	3,359,260	315,444,876
MEDICAL EXPENSES								
Provider Capitation	43,944,463	46,767,503	16,624,998	107,336,964	13,229,707	563,960		121,130,632
Facilities	22,645,104	20,694,148	869,636	44,208,887	4,438,961	469,245	579,355	49,696,448
Professional Claims	19,039,232	8,391,661	978,526	28,409,419	982,127	76,429	531,792	29,999,767
Prescription Drugs	17,319,525	22,334,493	8,602,347	48,256,364	5,830,392	559,063	288,548	54,934,366
MLTSS	32,431,314	2,687,286	1,642,096	36,760,696	1,374,449	81,717	275	38,217,136
Medical Management	2,566,797	1,422,569	293,676	4,283,042	1,171,670	22,630	916,535	6,393,876
Quality Incentives	850,360	514,497	34,520	1,399,378	218,655		89,272	1,707,304
Reinsurance & Other	349,553	187,671	11,107	548,332	108,685		115,528	772,545
Total Medical Expenses	139,146,348	102,999,827	29,056,906	271,203,081	27,354,645	1,773,043	2,521,304	302,852,074
Medical Loss Ratio	91.5%	97.3%	130.6%	96.8%	91.1%	91.9%	75.1%	96.0%
GROSS MARGIN	**12,898,975**	**2,823,805**	**(6,808,011)**	**8,914,770**	**2,683,400**	**156,678**	**837,956**	**12,592,803**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,811,212	637,504	93,885	41,137	7,583,738
Professional fees				(90,745)	5,333	16,000	123	(69,288)
Purchased services				892,088	94,622	8,328	33,197	1,028,234
Printing & Postage				359,526	89,598	11,237	(3,911)	456,449
Depreciation & Amortization				313,914			2,018	315,932
Other expenses				1,282,832	38,157		1,811	1,322,799
Indirect cost allocation & Occupancy				(283,234)	578,790	39,333	4,084	338,973
Total Administrative Expenses				9,285,592	1,444,004	168,782	78,459	10,976,837
Admin Loss Ratio				3.3%	4.8%	8.7%	2.3%	3.5%
INCOME (LOSS) FROM OPERATIONS				(370,822)	1,239,396	(12,105)	759,497	1,615,966
INVESTMENT INCOME								841,484
TOTAL MCO TAX				(247,810)				(247,810)
TOTAL GRANT INCOME				15,028				15,028
OTHER INCOME				49				49
CHANGE IN NET ASSETS				**$ (603,556)**	**$ 1,239,396**	**$ (12,105)**	**$ 759,497**	**$ 2,224,716**
BUDGETED CHANGE IN NET ASSETS				2,265,393	(667,801)	68,186	284,575	3,200,353
VARIANCE TO BUDGET - FAV (UNFAV)				$ (2,868,949)	$ 1,907,197	$ (80,291)	$ 474,922	$ (975,637)

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Consolidated Revenue & Expenses: November 2020 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	2,531,861	1,267,731	56,902	3,856,494	72,842	7,894	1,923	3,939,153
REVENUES								
Capitation Revenue	806,020,504	$ 574,788,970	$ 111,471,540	$ 1,492,281,015	$ 145,180,898	$ 10,097,726	$ 16,188,073	$ 1,663,747,712
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	806,020,504	574,788,970	111,471,540	1,492,281,015	145,180,898	10,097,726	16,188,073	1,663,747,712
MEDICAL EXPENSES								
Provider Capitation	188,117,688	219,209,193	58,241,080	465,567,962	64,454,801	2,760,867		532,783,630
Facilities	115,851,805	127,782,034	13,456,486	257,090,325	22,288,577	2,246,159	3,190,386	284,815,447
Professional Claims	97,220,706	44,738,010	4,956,927	146,915,643	4,866,749	373,387	2,957,628	155,113,407
Prescription Drugs	99,539,407	123,686,491	23,854,134	247,080,033	30,839,980	2,943,067	1,425,191	282,288,269
MLTSS	177,006,290	14,378,771	9,617,446	201,002,506	7,208,774	191,988	(9,677)	208,393,591
Medical Management	11,754,384	6,919,280	1,465,936	20,139,600	5,410,786	168,158	4,259,683	29,978,228
Quality Incentives	4,255,375	2,525,359	169,160	6,949,894	1,080,840		108,397	8,139,130
Reinsurance & Other	58,707,481	47,210,076	63,476	105,981,034	712,244		556,373	107,249,651
Total Medical Expenses	752,453,136	586,449,215	111,824,645	1,450,726,996	136,862,750	8,683,626	12,487,980	1,608,761,353
Medical Loss Ratio	93.4%	102.0%	100.3%	97.2%	94.3%	86.0%	77.1%	96.7%
GROSS MARGIN	**53,567,368**	**(11,660,245)**	**(353,104)**	**41,554,019**	**8,318,148**	**1,414,100**	**3,700,093**	**54,986,360**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				33,630,340	3,530,343	433,458	609,816	38,203,957
Professional fees				689,228	114,437	80,000	657	884,322
Purchased services				3,690,062	452,939	40,039	72,736	4,255,776
Printing & Postage				1,122,166	427,262	26,833	56,904	1,633,165
Depreciation & Amortization				1,465,868			10,161	1,476,029
Other expenses				6,844,548	219,937	205	15,208	7,079,898
Indirect cost allocation & Occupancy				(1,286,226)	2,893,951	196,663	17,682	1,822,070
Total Administrative Expenses				46,155,986	7,638,868	777,198	783,165	55,355,217
Admin Loss Ratio				3.1%	5.3%	7.7%	4.8%	3.3%
INCOME (LOSS) FROM OPERATIONS				(4,601,967)	679,280	636,902	2,916,928	(368,857)
INVESTMENT INCOME								4,215,572
TOTAL MCO TAX				(2,290,026)				(2,290,026)
TOTAL GRANT INCOME				35,503				35,503
OTHER INCOME				315				315
CHANGE IN NET ASSETS				**$ (6,856,176)**	**$ 679,280**	**$ 636,902**	**$ 2,916,928**	**$ 1,592,506**
BUDGETED CHANGE IN NET ASSETS				(6,459,422)	(4,764,896)	260,845	960,317	(3,753,156)
VARIANCE TO BUDGET - FAV (UNFAV)				$ (396,754)	$ 5,444,176	$ 376,057	$ 1,956,611	$ 5,345,662

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CalOptima
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Balance Sheet: As of November 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$426,995,645	Accounts Payable	$32,500,256
Investments	754,644,748	Medical Claims liability	958,934,443
Capitation receivable	349,721,083	Accrued Payroll Liabilities	15,198,654
Receivables - Other	35,272,184	Deferred Revenue	21,199,984
Prepaid expenses	5,653,844	Deferred Lease Obligations	147,080
		Capitation and Withholds	161,760,413
Total Current Assets	**1,572,287,505**	**Total Current Liabilities**	**1,189,740,829**
Capital Assets			
Furniture & Equipment	40,923,636		
Building/Leasehold Improvements	10,673,971		
505 City Parkway West	51,628,218		
	103,225,825		
Less: accumulated depreciation	(55,869,017)		
Capital assets, net	47,356,807		
		Other (than pensions) post employment benefits liability	26,050,460
Other Assets		Net Pension Liabilities	27,429,763
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	57,198,913		
Board-designated assets:			
Cash and Cash Equivalents	1,469,128		
Long-term Investments	586,348,702		
Total Board-designated Assets	587,817,830		
		TOTAL LIABILITIES	**1,243,221,051**
Total Other Assets	645,316,743	Deferred Inflows	
		Excess Earnings	506,547
		OPEB 75 Difference in Experience	804,000
		Change in Assumptions	3,728,725
		OPEB Changes in Assumptions	1,638,000
TOTAL ASSETS	**2,264,961,056**	Net Position	
		TNE	102,478,286
		Funds in Excess of TNE	924,245,517
Deferred Outflows		**TOTAL NET POSITION**	1,026,723,803
Contributions	1,047,297		
Difference in Experience	4,280,308		
Changes in Assumptions	5,060,465		
OPEB 75 Changes in Assumptions	703,000		
Pension Contributions	570,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,276,622,126**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,276,622,126**

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Board Designated Reserve and TNE Analysis: As of November 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,829,332				
	Tier 1 - MetLife	159,624,375				
	Tier 1 - Wells Capital	159,951,226				
Board-designated Reserve		480,404,933	320,431,304	501,678,271	159,973,629	(21,273,338)
TNE Requirement	Tier 2 - MetLife	107,412,898	102,478,286	102,478,286	4,934,612	4,934,612
	Consolidated:	**587,817,830**	**422,909,590**	**604,156,557**	**164,908,240**	**(16,338,727)**
	Current reserve level	*1.95*	*1.40*	*2.00*		

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CalOptima
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Our Mission

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

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CalOptima
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UNAUDITED FINANCIAL STATEMENTS

November 30, 2020

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CalOptima - Consolidated
Financial Highlights
For the Five Months Ended November 30, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
801,270	797,994	3,276	0.4%	Member Months	3,939,153	3,928,127	11,026	0.3%
315,444,876	324,570,016	(9,125,140)	(2.8%)	Revenues	1,663,747,712	1,605,377,196	58,370,516	3.6%
302,852,074	310,689,111	7,837,038	2.5%	Medical Expenses	1,608,761,353	1,552,076,196	(56,685,157)	(3.7%)
10,976,837	11,930,552	953,715	8.0%	Administrative Expenses	55,355,217	63,304,156	7,948,939	12.6%
1,615,966	**1,950,353**	**(334,387)**	**(17.1%)**	**Operating Margin**	**(368,857)**	**(10,003,156)**	**9,634,299**	**96.3%**
608,750	1,250,000	(641,250)	(51.3%)	Non Operating Income (Loss)	1,961,363	6,250,000	(4,288,637)	(68.6%)
2,224,716	**3,200,353**	**(975,637)**	**(30.5%)**	**Change in Net Assets**	**1,592,506**	**(3,753,156)**	**5,345,662**	**142.4%**
96.0%	95.7%	(0.3%)		Medical Loss Ratio	96.7%	96.7%	(0.0%)	
3.5%	3.7%	0.2%		Administrative Loss Ratio	3.3%	3.9%	0.6%	
0.5%	0.6%	(0.1%)		Operating Margin Ratio	(0.0%)	(0.6%)	0.6%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
96.0%	95.7%	(0.3%)		*MLR (excluding Directed Payments)	96.5%	96.7%	0.2%	
3.5%	3.7%	0.2%		*ALR (excluding Directed Payments)	3.5%	3.9%	0.4%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Five Months Ended November 30, 2020

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	784,665	782,166	2,499	0.3%
OneCare Connect	14,587	14,027	560	4.0%
OneCare	1,625	1,378	247	17.9%
PACE	393	423	(30)	(7.1%)
Total	801,270	797,994	3,276	0.4%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (604)	$ 2,265	$ (2,869)	(126.6%)
OneCare Connect	1,239	(668)	1,907	285.6%
OneCare	(12)	68	(80)	(117.8%)
PACE	759	285	475	166.9%
Investment Income	841	1,250	(409)	(32.7%)
Total	$ 2,225	$ 3,200	$ (976)	(30.5%)

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.8%	95.8%	(1.0)
OneCare Connect	91.1%	96.6%	5.6
OneCare	91.9%	88.1%	(3.8)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,286	$ 10,079	$ 794	7.9%
OneCare Connect	1,444	1,535	91	5.9%
OneCare	169	132	(37)	(27.8%)
PACE	78	184	106	57.3%
Total	$ 10,977	$ 11,931	$ 954	8.0%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,081	1,161	80
OneCare Connect	188	210	21
OneCare	10	9	(1)
PACE	92	116	24
Total	1,371	1,496	125

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	726	674	52
OneCare Connect	77	67	11
OneCare	161	148	13
PACE	4	4	1
Total	968	893	76

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	3,856,494	3,848,781	7,713	0.2%
OneCare Connect	72,842	70,402	2,440	3.5%
OneCare	7,894	6,890	1,004	14.6%
PACE	1,923	2,054	(131)	(6.4%)
Total	3,939,153	3,928,127	11,026	0.3%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (6,856)	$ (6,459)	$ (397)	(6.1%)
OneCare Connect	679	(4,765)	5,444	114.3%
OneCare	637	261	376	144.2%
PACE	2,917	960	1,957	203.7%
Investment Income	4,216	6,250	(2,034)	(32.5%)
Total	$ 1,593	$ (3,753)	$ 5,346	142.4%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.2%	96.7%	(0.5)
OneCare Connect	94.3%	97.5%	3.2
OneCare	86.0%	88.8%	2.8

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 46,156	$ 53,747	$ 7,591	14.1%
OneCare Connect	7,639	8,037	398	5.0%
OneCare	777	684	(93)	(13.6%)
PACE	783	836	53	6.4%
Total	$ 55,355	$ 63,304	$ 7,949	12.6%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	5,421	5,804	383
OneCare Connect	951	1,049	98
OneCare	51	47	(4)
PACE	452	581	129
Total	6,875	7,481	605

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	711	663	48
OneCare Connect	77	67	9
OneCare	156	148	7
PACE	4	4	1
Total	948	882	66

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended November 30, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	801,270		797,994		3,276	
REVENUE						
Medi-Cal	$ 280,117,851	$ 356.99	$ 293,769,433	$ 375.58	$ (13,651,582)	$ (18.59)
OneCare Connect	30,038,045	2,059.23	25,684,974	1,831.11	4,353,071	228.12
OneCare	1,929,721	1,187.52	1,681,120	1,219.97	248,601	(32.45)
PACE	3,359,260	8,547.73	3,434,489	8,119.36	(75,229)	428.37
Total Operating Revenue	315,444,876	393.68	324,570,016	406.73	(9,125,140)	(13.05)
MEDICAL EXPENSES						
Medi-Cal	271,203,081	345.63	281,424,735	359.80	10,221,654	14.17
OneCare Connect	27,354,645	1,875.28	24,817,594	1,769.27	(2,537,051)	(106.01)
OneCare	1,773,043	1,091.10	1,480,827	1,074.62	(292,216)	(16.48)
PACE	2,521,304	6,415.53	2,965,955	7,011.71	444,651	596.18
Total Medical Expenses	302,852,074	377.97	310,689,111	389.34	7,837,037	11.37
GROSS MARGIN	12,592,803	15.71	13,880,905	17.39	(1,288,102)	(1.68)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,583,738	9.46	7,150,656	8.96	(433,082)	(0.50)
Professional fees	(69,288)	(0.09)	369,342	0.46	438,630	0.55
Purchased services	1,028,234	1.28	1,295,326	1.62	267,092	0.34
Printing & Postage	456,449	0.57	575,359	0.72	118,910	0.15
Depreciation & Amortization	315,932	0.39	460,570	0.58	144,638	0.19
Other expenses	1,322,799	1.65	1,696,439	2.13	373,640	0.48
Indirect cost allocation & Occupancy expense	338,973	0.42	382,860	0.48	43,887	0.06
Total Administrative Expenses	10,976,837	13.70	11,930,552	14.95	953,715	1.25
INCOME (LOSS) FROM OPERATIONS	1,615,966	2.02	1,950,353	2.44	(334,387)	(0.42)
INVESTMENT INCOME						
Interest income	892,068	1.11	1,250,000	1.57	(357,932)	(0.46)
Realized gain/(loss) on investments	526,413	0.66	-	-	526,413	0.66
Unrealized gain/(loss) on investments	(576,997)	(0.72)	-	-	(576,997)	(0.72)
Total Investment Income	841,484	1.05	1,250,000	1.57	(408,516)	(0.52)
TOTAL MCO TAX	(247,810)	(0.31)	(0)	-	(247,810)	(0.31)
TOTAL GRANT INCOME	15,028	0.02	-	-	15,028	0.02
OTHER INCOME	49	-	-	-	49	-
CHANGE IN NET ASSETS	**2,224,716**	**2.78**	**3,200,353**	**4.01**	**(975,637)**	**(1.23)**
MEDICAL LOSS RATIO	**96.0%**		**95.7%**		**-0.3%**	
ADMINISTRATIVE LOSS RATIO	**3.5%**		**3.7%**		**0.2%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Five Months Ended November 30, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	3,939,153		3,928,127		11,026	
REVENUE						
Medi-Cal	$ 1,492,281,015	$ 386.95	$ 1,450,960,048	$ 376.99	$ 41,320,967	$ 9.96
OneCare Connect	145,180,898	1,993.09	129,291,749	1,836.48	15,889,149	156.61
OneCare	10,097,726	1,279.16	8,433,057	1,223.96	1,664,669	55.20
PACE	16,188,073	8,418.13	16,692,342	8,126.75	(504,269)	291.38
Total Operating Revenue	1,663,747,712	422.36	1,605,377,196	408.69	58,370,516	13.67
MEDICAL EXPENSES						
Medi-Cal	1,450,726,996	376.18	1,403,672,880	364.71	(47,054,116)	(11.47)
OneCare Connect	136,862,750	1,878.90	126,019,433	1,790.00	(10,843,317)	(88.90)
OneCare	8,683,626	1,100.03	7,488,213	1,086.82	(1,195,413)	(13.21)
PACE	12,487,980	6,494.01	14,895,670	7,252.03	2,407,690	758.02
Total Medical Expenses	1,608,761,353	408.40	1,552,076,196	395.12	(56,685,157)	(13.28)
GROSS MARGIN	54,986,360	13.96	53,301,000	13.57	1,685,360	0.39
ADMINISTRATIVE EXPENSES						
Salaries and benefits	38,203,957	9.70	39,503,730	10.06	1,299,773	0.36
Professional fees	884,322	0.22	1,846,710	0.47	962,388	0.25
Purchased services	4,255,776	1.08	6,400,381	1.63	2,144,605	0.55
Printing & Postage	1,633,165	0.41	2,854,295	0.73	1,221,130	0.32
Depreciation & Amortization	1,476,029	0.37	2,302,850	0.59	826,821	0.22
Other expenses	7,079,898	1.80	8,472,659	2.16	1,392,761	0.36
Indirect cost allocation & Occupancy expense	1,822,070	0.46	1,923,531	0.49	101,461	0.03
Total Administrative Expenses	55,355,217	14.05	63,304,156	16.12	7,948,939	2.07
INCOME (LOSS) FROM OPERATIONS	(368,857)	(0.09)	(10,003,156)	(2.55)	9,634,299	2.46
INVESTMENT INCOME						
Interest income	5,630,558	1.43	6,250,000	1.59	(619,442)	(0.16)
Realized gain/(loss) on investments	3,308,880	0.84	-	-	3,308,880	0.84
Unrealized gain/(loss) on investments	(4,723,866)	(1.20)	-	-	(4,723,866)	(1.20)
Total Investment Income	4,215,572	1.07	6,250,000	1.59	(2,034,428)	(0.52)
TOTAL MCO TAX	(2,290,026)	(0.58)	-	-	(2,290,026)	(0.58)
TOTAL GRANT INCOME	35,503	0.01	-	-	35,503	0.01
OTHER INCOME	315	-	-	-	315	-
CHANGE IN NET ASSETS	**1,592,506**	**0.40**	**(3,753,156)**	**(0.96)**	**5,345,662**	**1.36**
MEDICAL LOSS RATIO	**96.7%**		**96.7%**		**0.0%**	
ADMINISTRATIVE LOSS RATIO	**3.3%**		**3.9%**		**0.6%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended November 30, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	511,945	261,463	11,257	784,665	14,587	1,625	393	801,270
REVENUES								
Capitation Revenue	152,045,323	$ 105,823,633	$ 22,248,895	$ 280,117,851	$ 30,038,045	$ 1,929,721	$ 3,359,260	$ 315,444,876
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	152,045,323	105,823,633	22,248,895	280,117,851	30,038,045	1,929,721	3,359,260	315,444,876
MEDICAL EXPENSES								
Provider Capitation	43,944,463	46,767,503	16,624,998	107,336,964	13,229,707	563,960		121,130,632
Facilities	22,645,104	20,694,148	869,636	44,208,887	4,438,961	469,245	579,355	49,696,448
Professional Claims	19,039,232	8,391,661	978,526	28,409,419	982,127	76,429	531,792	29,999,767
Prescription Drugs	17,319,525	22,334,493	8,602,347	48,256,364	5,830,392	559,063	288,548	54,934,366
MLTSS	32,431,314	2,687,286	1,642,096	36,760,696	1,374,449	81,717	275	38,217,136
Medical Management	2,566,797	1,422,569	293,676	4,283,042	1,171,670	22,630	916,535	6,393,876
Quality Incentives	850,360	514,497	34,520	1,399,378	218,655		89,272	1,707,304
Reinsurance & Other	349,553	187,671	11,107	548,332	108,685		115,528	772,545
Total Medical Expenses	139,146,348	102,999,827	29,056,906	271,203,081	27,354,645	1,773,043	2,521,304	302,852,074
Medical Loss Ratio	91.5%	97.3%	130.6%	96.8%	91.1%	91.9%	75.1%	96.0%
GROSS MARGIN	**12,898,975**	**2,823,805**	**(6,808,011)**	**8,914,770**	**2,683,400**	**156,678**	**837,956**	**12,592,803**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,811,212	637,504	93,885	41,137	7,583,738
Professional fees				(90,745)	5,333	16,000	123	(69,288)
Purchased services				892,088	94,622	8,328	33,197	1,028,234
Printing & Postage				359,526	89,598	11,237	(3,911)	456,449
Depreciation & Amortization				313,914			2,018	315,932
Other expenses				1,282,832	38,157		1,811	1,322,799
Indirect cost allocation & Occupancy				(283,234)	578,790	39,333	4,084	338,973
Total Administrative Expenses				9,285,592	1,444,004	168,782	78,459	10,976,837
Admin Loss Ratio				3.3%	4.8%	8.7%	2.3%	3.5%
INCOME (LOSS) FROM OPERATIONS				(370,822)	1,239,396	(12,105)	759,497	1,615,966
INVESTMENT INCOME								841,484
TOTAL MCO TAX				(247,810)				(247,810)
TOTAL GRANT INCOME				15,028				15,028
OTHER INCOME				49				49
CHANGE IN NET ASSETS				**$ (603,556)**	**$ 1,239,396**	**$ (12,105)**	**$ 759,497**	**$ 2,224,716**
BUDGETED CHANGE IN NET ASSETS				2,265,393	(667,801)	68,186	284,575	3,200,353
VARIANCE TO BUDGET - FAV (UNFAV)				$ (2,868,949)	$ 1,907,197	$ (80,291)	$ 474,922	$ (975,637)

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Five Months Ended November 30, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	2,531,861	1,267,731	56,902	3,856,494	72,842	7,894	1,923	3,939,153
REVENUES								
Capitation Revenue	806,020,504	$ 574,788,970	$ 111,471,540	$ 1,492,281,015	$ 145,180,898	$ 10,097,726	$ 16,188,073	$ 1,663,747,712
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	806,020,504	574,788,970	111,471,540	1,492,281,015	145,180,898	10,097,726	16,188,073	1,663,747,712
MEDICAL EXPENSES								
Provider Capitation	188,117,688	219,209,193	58,241,080	465,567,962	64,454,801	2,760,867		532,783,630
Facilities	115,851,805	127,782,034	13,456,486	257,090,325	22,288,577	2,246,159	3,190,386	284,815,447
Professional Claims	97,220,706	44,738,010	4,956,927	146,915,643	4,866,749	373,387	2,957,628	155,113,407
Prescription Drugs	99,539,407	123,686,491	23,854,134	247,080,033	30,839,980	2,943,067	1,425,191	282,288,269
MLTSS	177,006,290	14,378,771	9,617,446	201,002,506	7,208,774	191,988	(9,677)	208,393,591
Medical Management	11,754,384	6,919,280	1,465,936	20,139,600	5,410,786	168,158	4,259,683	29,978,228
Quality Incentives	4,255,375	2,525,359	169,160	6,949,894	1,080,840		108,397	8,139,130
Reinsurance & Other	58,707,481	47,210,076	63,476	105,981,034	712,244		556,373	107,249,651
Total Medical Expenses	752,453,136	586,449,215	111,824,645	1,450,726,996	136,862,750	8,683,626	12,487,980	1,608,761,353
Medical Loss Ratio	93.4%	102.0%	100.3%	97.2%	94.3%	86.0%	77.1%	96.7%
GROSS MARGIN	**53,567,368**	**(11,660,245)**	**(353,104)**	**41,554,019**	**8,318,148**	**1,414,100**	**3,700,093**	**54,986,360**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				33,630,340	3,530,343	433,458	609,816	38,203,957
Professional fees				689,228	114,437	80,000	657	884,322
Purchased services				3,690,062	452,939	40,039	72,736	4,255,776
Printing & Postage				1,122,166	427,262	26,833	56,904	1,633,165
Depreciation & Amortization				1,465,868			10,161	1,476,029
Other expenses				6,844,548	219,937	205	15,208	7,079,898
Indirect cost allocation & Occupancy				(1,286,226)	2,893,951	196,663	17,682	1,822,070
Total Administrative Expenses				46,155,986	7,638,868	777,198	783,165	55,355,217
Admin Loss Ratio				3.1%	5.3%	7.7%	4.8%	3.3%
INCOME (LOSS) FROM OPERATIONS				(4,601,967)	679,280	636,902	2,916,928	(368,857)
INVESTMENT INCOME								4,215,572
TOTAL MCO TAX				(2,290,026)				(2,290,026)
TOTAL GRANT INCOME				35,503				35,503
OTHER INCOME				315				315
CHANGE IN NET ASSETS				**$ (6,856,176)**	**$ 679,280**	**$ 636,902**	**$ 2,916,928**	**$ 1,592,506**
BUDGETED CHANGE IN NET ASSETS				(6,459,422)	(4,764,896)	260,845	960,317	(3,753,156)
VARIANCE TO BUDGET - FAV (UNFAV)				$ (396,754)	$ 5,444,176	$ 376,057	$ 1,956,611	$ 5,345,662

November 30, 2020 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $2.2 million, $1.0 million unfavorable to budget
- Operating surplus is $1.6 million, with a surplus in non-operating income of $0.6 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $1.6 million, $5.3 million favorable to budget
- Operating deficit is ($0.4) million, with a surplus in non-operating income of $2.0 million

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(0.4)	2.3	(2.6)	Medi-Cal	(4.6)	(6.5)	1.9
1.2	(0.7)	1.9	OCC	0.7	(4.8)	5.4
(0.0)	0.1	(0.1)	OneCare	0.6	0.3	0.4
0.8	0.3	0.5	PACE	2.9	1.0	2.0
1.6	**2.0**	**(0.3)**	**Operating**	**(0.4)**	**(10.0)**	**9.6**
0.6	1.3	(0.6)	Inv./Rental Inc, MCO tax	2.0	6.3	(4.3)
0.6	**1.3**	**(0.6)**	**Non-Operating**	**2.0**	**6.3**	**(4.3)**
2.2	**3.2**	**(1.0)**	**TOTAL**	**1.6**	**(3.8)**	**5.3**

CalOptima - Consolidated
Enrollment Summary
For the Five Months Ended November 30, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
113,720	110,934	2,786	2.5%	SPD	566,582	554,278	12,304	2.2%
500	477	23	4.8%	BCCTP	2,563	2,425	138	5.7%
292,943	311,636	(18,693)	(6.0%)	TANF Child	1,452,219	1,525,738	(73,519)	(4.8%)
99,872	93,695	6,177	6.6%	TANF Adult	486,192	458,958	27,234	5.9%
4,910	3,513	1,397	39.8%	LTC	24,305	17,545	6,760	38.5%
261,463	249,980	11,483	4.6%	MCE	1,267,731	1,230,178	37,553	3.1%
11,257	11,931	(674)	(5.6%)	WCM	56,902	59,659	(2,757)	(4.6%)
784,665	**782,166**	**2,499**	**0.3%**	**Medi-Cal Total**	**3,856,494**	**3,848,781**	**7,713**	**0.2%**
14,587	**14,027**	**560**	**4.0%**	**OneCare Connect**	**72,842**	**70,402**	**2,440**	**3.5%**
1,625	**1,378**	**247**	**17.9%**	**OneCare**	**7,894**	**6,890**	**1,004**	**14.6%**
393	**423**	**(30)**	**(7.1%)**	**PACE**	**1,923**	**2,054**	**(131)**	**(6.4%)**
801,270	**797,994**	**3,276**	**0.4%**	**CalOptima Total**	**3,939,153**	**3,928,127**	**11,026**	**0.3%**
				Enrollment (by Network)				
179,319	174,135	5,184	3.0%	HMO	874,930	858,544	16,386	1.9%
220,713	225,777	(5,064)	(2.2%)	PHC	1,087,018	1,109,910	(22,892)	(2.1%)
190,479	192,848	(2,369)	(1.2%)	Shared Risk Group	926,798	941,397	(14,599)	(1.6%)
194,154	189,406	4,748	2.5%	Fee for Service	967,748	938,930	28,818	3.1%
784,665	**782,166**	**2,499**	**0.3%**	**Medi-Cal Total**	**3,856,494**	**3,848,781**	**7,713**	**0.2%**
14,587	**14,027**	**560**	**4.0%**	**OneCare Connect**	**72,842**	**70,402**	**2,440**	**3.5%**
1,625	**1,378**	**247**	**17.9%**	**OneCare**	**7,894**	**6,890**	**1,004**	**14.6%**
393	**423**	**(30)**	**(7.1%)**	**PACE**	**1,923**	**2,054**	**(131)**	**(6.4%)**
801,270	**797,994**	**3,276**	**0.4%**	**CalOptima Total**	**3,939,153**	**3,928,127**	**11,026**	**0.3%**

CalOptima
Enrollment Trend by Network
Fiscal Year 2021

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,536	10,583	10,588	10,639	10,658								53,004	51,771	1,233
BCCTP	1	1	1	1	1								5	5	0
TANF Child	54,644	55,088	55,115	55,276	55,934								276,057	287,451	(11,394)
TANF Adult	29,033	29,687	30,001	30,679	30,990								150,390	144,870	5,520
LTC	(1)	402	197	215	239								1,052	10	1,042
MCE	74,441	75,955	76,054	78,435	79,490								384,375	364,212	20,163
WCM	1,721	1,726	2,086	2,507	2,007								10,047	10,225	(178)
Total	**170,375**	**173,442**	**174,042**	**177,752**	**179,319**								**874,930**	**858,544**	**16,386**
PHCs															
SPD	7,145	7,205	6,855	6,760	7,010								34,975	35,112	(137)
BCCTP													-		0
TANF Child	149,810	151,008	148,874	150,336	152,122								752,150	786,896	(34,746)
TANF Adult	11,688	12,097	12,071	12,492	12,728								61,076	56,961	4,115
LTC		158	81	65	76								380	5	375
MCE	39,815	40,711	39,935	41,371	41,820								203,652	195,021	8,631
WCM	5,625	5,716	7,990	8,497	6,957								34,785	35,915	(1,130)
Total	**214,083**	**216,895**	**215,806**	**219,521**	**220,713**								**1,087,018**	**1,109,910**	**(22,892)**
Shared Risk Groups															
SPD	10,264	10,312	10,068	10,117	10,120								50,881	50,696	185
BCCTP													-		0
TANF Child	58,289	58,687	57,269	58,133	58,881								291,259	318,098	(26,839)
TANF Adult	28,914	29,648	29,235	30,414	30,910								149,121	145,861	3,260
LTC	1	365	178	209	217								970	10	960
MCE	82,747	84,907	83,063	87,432	88,969								427,118	418,268	8,850
WCM	924	1,000	1,954	2,189	1,382								7,449	8,464	(1,015)
Total	**181,139**	**184,919**	**181,767**	**188,494**	**190,479**								**926,798**	**941,397**	**(14,599)**
Fee for Service (Dual)															
SPD	74,615	75,198	75,269	76,815	76,628								378,525	367,389	11,136
BCCTP	12	17	18	18	14								79	85	(6)
TANF Child	1	1	1	1	1								5	10	(5)
TANF Adult	909	1,266	994	1,107	1,015								5,291	4,898	393
LTC	3,079	4,461	3,855	3,838	3,818								19,051	15,805	3,246
MCE	1,658	1,859	1,948	2,077	2,138								9,680	7,285	2,395
WCM	13	17	16	17	15								78	65	13
Total	**80,287**	**82,819**	**82,101**	**83,873**	**83,629**								**412,709**	**395,537**	**17,172**
Fee for Service (Non-Dual - Total)															
SPD	9,830	9,822	10,264	9,977	9,304								49,197	49,310	(113)
BCCTP	497	492	499	506	485								2,479	2,335	144
TANF Child	25,494	27,007	28,092	26,150	26,005								132,748	133,283	(535)
TANF Adult	23,028	24,014	24,847	24,196	24,229								120,314	106,368	13,946
LTC	351	788	580	573	560								2,852	1,715	1,137
MCE	45,498	47,292	52,445	48,625	49,046								242,906	245,392	(2,486)
WCM	791	806	974	1,076	896								4,543	4,990	(447)
Total	**105,489**	**110,221**	**117,701**	**111,103**	**110,525**								**555,039**	**543,393**	**11,646**
SPD	112,390	113,120	113,044	114,308	113,720								566,582	554,278	12,304
BCCTP	510	510	518	525	500								2,563	2,425	138
TANF Child	288,238	291,791	289,351	289,896	292,943								1,452,219	1,525,738	(73,519)
TANF Adult	93,572	96,712	97,148	98,888	99,872								486,192	458,958	27,234
LTC	3,430	6,174	4,891	4,900	4,910								24,305	17,545	6,760
MCE	244,159	250,724	253,445	257,940	261,463								1,267,731	1,230,178	37,553
WCM	9,074	9,265	13,020	14,286	11,257								56,902	59,659	(2,757)
Total Medi-Cal MM	**751,373**	**768,296**	**771,417**	**780,743**	**784,665**								**3,856,494**	**3,848,781**	**7,713**
OneCare Connect	**14,465**	**14,541**	**14,529**	**14,720**	**14,587**								**72,842**	**70,402**	**2,440**
OneCare	**1,525**	**1,523**	**1,594**	**1,627**	**1,625**								**7,894**	**6,890**	**1,004**
PACE	**382**	**381**	**380**	**387**	**393**								**1,923**	**2,054**	**(131)**
Grand Total	**767,745**	**784,741**	**787,920**	**797,477**	**801,270**								**3,939,153**	**3,928,127**	**11,026**

ENROLLMENT:

Overall, November enrollment was 801,270

- Favorable to budget 3,276 or 0.4%
- Increased 3,793 or 0.5% from prior month (PM) (October 2020)
- Increased 45,731 or 6.1% from prior year (PY) (November 2019)

Medi-Cal enrollment was 784,665

- Favorable to budget 2,499 or 0.3%
  - Medi-Cal Expansion (MCE) favorable 11,483
  - Seniors and Persons with Disabilities (SPD) favorable 2,786
  - Long-Term Care (LTC) favorable 1,397
  - Breast and Cervical Cancer Treatment Program (BCCTP) favorable 23
  - Temporary Assistance for Needy Families (TANF) unfavorable 12,516
  - Whole Child Model (WCM) unfavorable 674 due to county adjustments
- Increased 3,922 from PM

OneCare Connect enrollment was 14,587

- Favorable to budget 560 or 4.0%
- Decreased 133 from PM

OneCare enrollment was 1,625

- Favorable to budget 247 or 17.9%
- Decreased 2 from PM

PACE enrollment was 393

- Unfavorable to budget 30 or 7.1%
- Increased 6 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
784,665	**782,166**	**2,499**	**0.3%**	**Member Months**	**3,856,494**	**3,848,781**	**7,713**	**0.2%**
				Revenues				
280,117,851	293,769,433	(13,651,582)	(4.6%)	Capitation Revenue	1,492,281,015	1,450,960,048	41,320,967	2.8%
280,117,851	**293,769,433**	**(13,651,582)**	**(4.6%)**	**Total Operating Revenue**	**1,492,281,015**	**1,450,960,048**	**41,320,967**	**2.8%**
				Medical Expenses				
108,736,342	99,626,171	(9,110,171)	(9.1%)	Provider Capitation	472,517,855	489,874,854	17,356,999	3.5%
44,208,887	57,806,764	13,597,877	23.5%	Facilities Claims	257,090,325	289,017,017	31,926,692	11.0%
28,409,419	32,605,965	4,196,546	12.9%	Professional Claims	146,915,643	163,552,106	16,636,463	10.2%
48,256,364	46,456,156	(1,800,208)	(3.9%)	Prescription Drugs	247,080,033	232,653,492	(14,426,541)	(6.2%)
36,760,696	39,618,916	2,858,220	7.2%	MLTSS	201,002,506	201,108,941	106,435	0.1%
4,283,042	4,706,757	423,715	9.0%	Medical Management	20,139,600	24,446,438	4,306,838	17.6%
548,332	604,006	55,674	9.2%	Reinsurance & Other	105,981,034	3,020,032	(102,961,002)	(3409.3%)
271,203,081	**281,424,735**	**10,221,654**	**3.6%**	**Total Medical Expenses**	**1,450,726,996**	**1,403,672,880**	**(47,054,116)**	**(3.4%)**
8,914,770	**12,344,698**	**(3,429,928)**	**(27.8%)**	**Gross Margin**	**41,554,019**	**47,287,168**	**(5,733,149)**	**(12.1%)**
				Administrative Expenses				
6,811,212	6,256,613	(554,599)	(8.9%)	Salaries, Wages & Employee Benefits	33,630,340	34,619,906	989,566	2.9%
(90,745)	313,093	403,838	129.0%	Professional Fees	689,228	1,565,465	876,237	56.0%
892,088	1,142,513	250,425	21.9%	Purchased Services	3,690,062	5,723,816	2,033,754	35.5%
359,526	443,433	83,907	18.9%	Printing and Postage	1,122,166	2,217,165	1,094,999	49.4%
313,914	458,500	144,586	31.5%	Depreciation & Amortization	1,465,868	2,292,500	826,632	36.1%
1,282,832	1,675,504	392,672	23.4%	Other Operating Expenses	6,844,548	8,369,876	1,525,328	18.2%
(283,234)	(210,351)	72,883	34.6%	Indirect Cost Allocation, Occupancy Expense	(1,286,226)	(1,042,138)	244,088	23.4%
9,285,592	**10,079,305**	**793,713**	**7.9%**	**Total Administrative Expenses**	**46,155,986**	**53,746,590**	**7,590,604**	**14.1%**
				Operating Tax				
12,220,940	15,143,443	(2,922,503)	(19.3%)	Tax Revenue	60,053,724	74,533,927	(14,480,203)	(19.4%)
12,468,750	15,143,443	2,674,693	17.7%	Premium Tax Expense	62,343,750	74,533,927	12,190,177	16.4%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
(247,810)	(0)	(247,810)	**0.0%**	**Total Net Operating Tax**	(2,290,026)	-	(2,290,026)	**0.0%**
				Grant Income				
108,089	-	108,089	0.0%	Grant Revenue	263,222	-	263,222	0.0%
85,223	-	(85,223)	0.0%	Grant expense - Service Partner	201,248	-	(201,248)	0.0%
7,839	-	(7,839)	0.0%	Grant expense - Administrative	26,472	-	(26,472)	0.0%
15,028	-	15,028	**0.0%**	**Total Grant Income**	35,503	-	35,503	**0.0%**
49	**-**	**49**	**0.0%**	**Other income**	**315**	**-**	**315**	**0.0%**
(603,556)	**2,265,393**	**(2,868,949)**	**(126.6%)**	**Change in Net Assets**	**(6,856,176)**	**(6,459,422)**	**(396,754)**	**(6.1%)**
96.8%	***95.8%***	***(1.0%)***	***(1.1%)***	***Medical Loss Ratio***	***97.2%***	***96.7%***	***(0.5%)***	***(0.5%)***
3.3%	***3.4%***	***0.1%***	***3.4%***	***Admin Loss Ratio***	***3.1%***	***3.7%***	***0.6%***	***16.5%***

MEDI-CAL INCOME STATEMENT – NOVEMBER MONTH:

REVENUES of $280.1 million are unfavorable to budget $13.7 million driven by:

- Favorable volume related variance of $0.9 million
- Unfavorable price related variance of $14.6 million
  - $4.1 million of Behavioral Health Treatment (BHT) revenue due to retroactive utilization report submitted by Kaiser.
  - $3.3 million of Proposition 56 risk corridor reserve
  - Offset by $22.2 million due to updated guidance for Gross Medical Expenditures (GME) risk corridor reserve for global sub-capitation

MEDICAL EXPENSES of $271.2 million are favorable to budget $10.2 million driven by:

- Unfavorable volume related variance of $0.9 million
- Favorable price related variance of $11.1 million
  - Facilities Claims expense favorable variance of $13.8 million due to decreased utilization during COVID-19 pandemic
  - Professional Claims expense favorable variance of $4.3 million due to decreased utilization during COVID-19 pandemic
  - Managed Long Term Services and Supports (MLTSS) expense favorable variance of $3.0 million due to decreased utilization during COVID-19 pandemic
  - Medical Management expense favorable variance of $0.4 million due to decreased utilization during COVID-19 pandemic
  - Offset by Provider Capitation expense unfavorable variance of $8.8 million due to WCM
  - Prescription Drugs expense unfavorable variance of $1.7 million

ADMINISTRATIVE EXPENSES of $9.3 million are favorable to budget $0.8 million driven by:

- Other Non-Salary expense favorable to budget $1.3 million
- Salaries & Benefit expense unfavorable to budget $0.6 million

CHANGE IN NET ASSETS is ($0.6) million for the month, unfavorable to budget $2.9 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Five Months Ending November 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,587	**14,027**	**560**	**4.0%**	**Member Months**	**72,842**	**70,402**	**2,440**	**3.5%**
				Revenues				
2,854,209	2,707,941	146,268	5.4%	Medi-Cal Capitation Revenue	15,494,225	13,591,873	1,902,352	14.0%
22,507,166	17,777,422	4,729,744	26.6%	Medicare Capitation Revenue Part C	104,437,214	89,594,158	14,843,056	16.6%
4,676,669	5,199,611	(522,942)	(10.1%)	Medicare Capitation Revenue Part D	25,249,459	26,105,718	(856,259)	(3.3%)
30,038,045	**25,684,974**	**4,353,071**	**16.9%**	**Total Operating Revenue**	**145,180,898**	**129,291,749**	**15,889,149**	**12.3%**
				Medical Expenses				
13,448,362	11,312,542	(2,135,820)	(18.9%)	Provider Capitation	65,535,641	57,130,344	(8,405,297)	(14.7%)
4,438,961	3,988,663	(450,298)	(11.3%)	Facilities Claims	22,288,577	20,089,047	(2,199,530)	(10.9%)
982,127	926,520	(55,607)	(6.0%)	Ancillary	4,866,749	4,683,003	(183,746)	(3.9%)
1,374,449	1,501,658	127,209	8.5%	MLTSS	7,208,774	7,716,358	507,584	6.6%
5,830,392	5,788,065	(42,327)	(0.7%)	Prescription Drugs	30,839,980	29,373,989	(1,465,990)	(5.0%)
1,171,670	1,085,360	(86,310)	(8.0%)	Medical Management	5,410,786	5,947,568	536,782	9.0%
108,685	214,786	106,101	49.4%	Other Medical Expenses	712,244	1,079,124	366,880	34.0%
27,354,645	**24,817,594**	**(2,537,051)**	**(10.2%)**	**Total Medical Expenses**	**136,862,750**	**126,019,433**	**(10,843,317)**	**(8.6%)**
2,683,400	**867,380**	**1,816,020**	**209.4%**	**Gross Margin**	**8,318,148**	**3,272,316**	**5,045,832**	**154.2%**
				Administrative Expenses				
637,504	715,816	78,312	10.9%	Salaries, Wages & Employee Benefits	3,530,343	3,938,399	408,056	10.4%
5,333	40,083	34,750	86.7%	Professional Fees	114,437	200,415	85,978	42.9%
94,622	103,412	8,790	8.5%	Purchased Services	452,939	517,060	64,121	12.4%
89,598	106,517	16,919	15.9%	Printing and Postage	427,262	532,585	105,323	19.8%
38,157	15,861	(22,296)	(140.6%)	Other Operating Expenses	219,937	81,293	(138,644)	(170.5%)
578,790	553,492	(25,298)	(4.6%)	Indirect Cost Allocation	2,893,951	2,767,460	(126,491)	(4.6%)
1,444,004	**1,535,181**	**91,177**	**5.9%**	**Total Administrative Expenses**	**7,638,868**	**8,037,212**	**398,344**	**5.0%**
1,239,396	**(667,801)**	**1,907,197**	**285.6%**	**Change in Net Assets**	**679,280**	**(4,764,896)**	**5,444,176**	**114.3%**
91.1%	***96.6%***	***5.6%***	***5.8%***	***Medical Loss Ratio***	***94.3%***	***97.5%***	***3.2%***	***3.3%***
4.8%	***6.0%***	***1.2%***	***19.6%***	***Admin Loss Ratio***	***5.3%***	***6.2%***	***1.0%***	***15.4%***

ONECARE CONNECT INCOME STATEMENT– NOVEMBER MONTH:

REVENUES of $30.0 million are favorable to budget $4.4 million driven by:

- Favorable volume related variance of $1.0 million
- Favorable price related variance of $3.3 million due to:
  - Calendar year (CY) 2020 Quality Withhold (QW) accrued revenue of $4.0 million
  - Offset by CY 2019 Part D risk sharing reserve adjustment of $0.4 million

MEDICAL EXPENSES of $27.4 million are unfavorable to budget $2.5 million driven by:

- Unfavorable volume related variance of $1.0 million
- Unfavorable price related variance of $1.5 million
  - Provider Capitation expense unfavorable variance of $1.7 million due to CY 2020 QW payable to the Health Networks (HN)
  - Facilities Claims expense unfavorable variance of $0.3 million
  - Offset by Prescription drug expense favorable variance of $0.2 million
  - MLTSS expense favorable variance of $0.2 million
  - Other Medical Expenses favorable variance of $0.1 million

ADMINISTRATIVE EXPENSES of $1.4 million are favorable to budget $0.1 million

CHANGE IN NET ASSETS is $1.2 million, favorable to budget $1.9 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,625	**1,378**	**247**	**17.9%**	**Member Months**	**7,894**	**6,890**	**1,004**	**14.6%**
				Revenues				
1,431,716	1,144,084	287,632	25.1%	Medicare Part C revenue	6,939,919	5,747,377	1,192,542	20.7%
498,005	537,036	(39,031)	(7.3%)	Medicare Part D revenue	3,157,807	2,685,680	472,127	17.6%
1,929,721	**1,681,120**	**248,601**	**14.8%**	**Total Operating Revenue**	**10,097,726**	**8,433,057**	**1,664,669**	**19.7%**
				Medical Expenses				
563,960	443,011	(120,949)	(27.3%)	Provider Capitation	2,760,867	2,225,466	(535,401)	(24.1%)
469,245	449,786	(19,459)	(4.3%)	Inpatient	2,246,159	2,273,797	27,638	1.2%
76,429	42,560	(33,869)	(79.6%)	Ancillary	373,387	214,549	(158,838)	(74.0%)
81,717	25,059	(56,658)	(226.1%)	Skilled Nursing Facilities	191,988	127,803	(64,185)	(50.2%)
559,063	479,790	(79,273)	(16.5%)	Prescription Drugs	2,943,067	2,429,379	(513,688)	(21.1%)
22,630	40,621	17,991	44.3%	Medical Management	168,158	217,219	49,061	22.6%
1,773,043	**1,480,827**	**(292,216)**	**(19.7%)**	**Total Medical Expenses**	**8,683,626**	**7,488,213**	**(1,195,413)**	**(16.0%)**
156,678	**200,293**	**(43,615)**	**(21.8%)**	**Gross Margin**	**1,414,100**	**944,844**	**469,256**	**49.7%**
				Administrative Expenses				
93,885	62,551	(31,334)	(50.1%)	Salaries, wages & employee benefits	433,458	336,219	(97,239)	(28.9%)
16,000	16,000	-	0.0%	Professional fees	80,000	80,000	-	0.0%
8,328	9,750	1,422	14.6%	Purchased services	40,039	48,750	8,711	17.9%
11,237	8,084	(3,153)	(39.0%)	Printing and postage	26,833	40,420	13,587	33.6%
-	537	537	100.0%	Other operating expenses	205	2,685	2,480	92.4%
39,333	35,185	(4,148)	(11.8%)	Indirect cost allocation, occupancy expens	196,663	175,925	(20,738)	(11.8%)
168,782	**132,107**	**(36,675)**	**(27.8%)**	**Total Administrative Expenses**	**777,198**	**683,999**	**(93,199)**	**(13.6%)**
(12,105)	**68,186**	**(80,291)**	**(117.8%)**	**Change in Net Assets**	**636,902**	**260,845**	**376,057**	**144.2%**
91.9%	***88.1%***	***(3.8%)***	***(4.3%)***	***Medical Loss Ratio***	***86.0%***	***88.8%***	***2.8%***	***3.2%***
8.7%	***7.9%***	***(0.9%)***	***(11.3%)***	***Admin Loss Ratio***	***7.7%***	***8.1%***	***0.4%***	***5.1%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
393	**423**	**(30)**	**(7.1%)**	**Member Months**	**1,923**	**2,054**	**(131)**	**-6.4%**
				Revenues				
2,460,145	2,661,813	(201,668)	(7.6%)	Medi-Cal Capitation Revenue	12,068,038	12,930,518	(862,480)	(6.7%)
726,542	621,858	104,684	16.8%	Medicare Part C Revenue	3,233,948	3,030,664	203,284	6.7%
172,572	150,818	21,754	14.4%	Medicare Part D Revenue	886,087	731,160	154,927	21.2%
3,359,260	**3,434,489**	**(75,229)**	**(2.2%)**	**Total Operating Revenue**	**16,188,073**	**16,692,342**	**(504,269)**	**(3.0%)**
				Medical Expenses				
916,535	889,893	(26,642)	(3.0%)	Medical Management	4,259,683	4,753,256	493,573	10.4%
579,355	797,064	217,709	27.3%	Facilities Claims	3,190,386	3,892,375	701,989	18.0%
531,792	670,381	138,589	20.7%	Professional Claims	2,957,628	3,266,799	309,171	9.5%
115,528	252,693	137,165	54.3%	Patient Transportation	556,373	1,239,848	683,475	55.1%
288,548	273,346	(15,202)	(5.6%)	Prescription Drugs	1,425,191	1,346,713	(78,478)	(5.8%)
275	64,164	63,889	99.6%	MLTSS	(9,677)	305,490	315,167	103.2%
89,272	18,414	(70,858)	(384.8%)	Other Expenses	108,397	91,189	(17,208)	(18.9%)
2,521,304	**2,965,955**	**444,651**	**15.0%**	**Total Medical Expenses**	**12,487,980**	**14,895,670**	**2,407,690**	**16.2%**
837,956	**468,534**	**369,422**	**78.8%**	**Gross Margin**	**3,700,093**	**1,796,672**	**1,903,421**	**105.9%**
				Administrative Expenses				
41,137	115,676	74,539	64.4%	Salaries, wages & employee benefits	609,816	609,206	(610)	(0.1%)
123	166	43	25.7%	Professional fees	657	830	173	20.9%
33,197	39,651	6,454	16.3%	Purchased services	72,736	110,755	38,019	34.3%
(3,911)	17,325	21,236	122.6%	Printing and postage	56,904	64,125	7,221	11.3%
2,018	2,070	52	2.5%	Depreciation & amortization	10,161	10,350	189	1.8%
1,811	4,537	2,726	60.1%	Other operating expenses	15,208	18,805	3,597	19.1%
4,084	4,534	450	9.9%	Indirect Cost Allocation, Occupancy Expense	17,682	22,284	4,602	20.7%
78,459	**183,959**	**105,500**	**57.3%**	**Total Administrative Expenses**	**783,165**	**836,355**	**53,190**	**6.4%**
				Operating Tax				
5,743	-	5,743	0.0%	Tax Revenue	28,448	-	28,448	0.0%
5,743	-	(5,743)	0.0%	Premium Tax Expense	28,448	-	(28,448)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
759,497	**284,575**	**474,922**	**166.9%**	**Change in Net Assets**	**2,916,928**	**960,317**	**1,956,611**	**203.7%**
75.1%	***86.4%***	***11.3%***	***13.1%***	***Medical Loss Ratio***	***77.1%***	***89.2%***	***12.1%***	***13.6%***
2.3%	***5.4%***	***3.0%***	***56.4%***	***Admin Loss Ratio***	***4.8%***	***5.0%***	***0.2%***	***3.4%***

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
36,194	55,000	18,806	34.2%	Purchase services	201,370	275,000	73,630	26.8%
171,588	177,250	5,662	3.2%	Depreciation & amortization	855,235	886,250	31,015	3.5%
18,423	18,500	77	0.4%	Insurance expense	92,114	92,500	386	0.4%
95,188	114,917	19,729	17.2%	Repair and maintenance	505,003	574,584	69,581	12.1%
43,103	41,250	(1,853)	(4.5%)	Other Operating Expense	287,497	206,250	(81,247)	(39.4%)
(364,496)	(406,917)	(42,421)	(10.4%)	Indirect allocation, Occupancy	(1,941,218)	(2,034,584)	(93,366)	(4.6%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

OTHER INCOME STATEMENTS – NOVEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($12.1) thousand, unfavorable to budget $80.3 thousand

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.8 million, favorable to budget $0.5 million

CalOptima
Balance Sheet
November 30, 2020

ASSETS		
Current Assets		
Operating Cash		$426,995,645
Investments		754,644,748
Capitation receivable		349,721,083
Receivables - Other		35,272,184
Prepaid expenses		5,653,844
Total Current Assets		**1,572,287,505**
Capital Assets		
Furniture & Equipment	40,923,636	
Building/Leasehold Improvements	10,673,971	
505 City Parkway West	51,628,218	
	103,225,825	
Less: accumulated depreciation	(55,869,017)	
Capital assets, net		47,356,807
Other Assets		
Restricted Deposit & Other		300,000
Homeless Health Reserve		57,198,913
Board-designated assets:		
Cash and Cash Equivalents		1,469,128
Long-term Investments		586,348,702
Total Board-designated Assets		587,817,830
Total Other Assets		645,316,743
TOTAL ASSETS		**2,264,961,056**
Deferred Outflows		
Contributions		1,047,297
Difference in Experience		4,280,308
Changes in Assumptions		5,060,465
OPEB 75 Changes in Assumptions		703,000
Pension Contributions		570,000
TOTAL ASSETS & DEFERRED OUTFLOWS		**2,276,622,126**

LIABILITIES & NET POSITION		
Current Liabilities		
Accounts Payable		$32,500,256
Medical Claims liability		958,934,443
Accrued Payroll Liabilities		15,198,654
Deferred Revenue		21,199,984
Deferred Lease Obligations		147,080
Capitation and Withholds		161,760,413
Total Current Liabilities		**1,189,740,829**
Other (than pensions) post employment benefits liability		26,050,460
Net Pension Liabilities		27,429,763
Bldg 505 Development Rights		-
TOTAL LIABILITIES		**1,243,221,051**
Deferred Inflows		
Excess Earnings		506,547
OPEB 75 Difference in Experience		804,000
Change in Assumptions		3,728,725
OPEB Changes in Assumptions		1,638,000
Net Position		
TNE		102,478,286
Funds in Excess of TNE		924,245,517
TOTAL NET POSITION		1,026,723,803
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION		**2,276,622,126**

CalOptima
Board Designated Reserve and TNE Analysis
as of November 30, 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,829,332				
	Tier 1 - MetLife	159,624,375				
	Tier 1 - Wells Capital	159,951,226				
Board-designated Reserve		480,404,933	320,431,304	501,678,271	159,973,629	(21,273,338)
TNE Requirement	Tier 2 - MetLife	107,412,898	102,478,286	102,478,286	4,934,612	4,934,612
	Consolidated:	**587,817,830**	**422,909,590**	**604,156,557**	**164,908,240**	**(16,338,727)**
	Current reserve level	*1.95*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
November 30, 2020

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	2,224,716	1,592,506
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	487,520	2,331,264
Changes in assets and liabilities:		
Prepaid expenses and other	57,260	1,045,364
Catastrophic reserves		
Capitation receivable	2,781,765	61,376,758
Medical claims liability	37,539,280	41,782,422
Deferred revenue	(41,446,493)	(2,223,712)
Payable to health networks	1,231,468	18,779,385
Accounts payable	(25,352,589)	(42,156,190)
Accrued payroll	1,678,949	2,110,125
Other accrued liabilities	(2,777)	(13,778)
Net cash provided by/(used in) operating activities	(20,800,902)	84,624,145
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	193,730,774	(30,458,436)
Change in Property and Equipment	(296,029)	(3,033,501)
Change in Board designated reserves	(667,607)	(2,933,937)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	192,767,138	(36,425,874)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	171,966,236	48,198,271
CASH AND CASH EQUIVALENTS, beginning of period	$255,029,409	378,797,374
CASH AND CASH EQUIVALENTS, end of period	**426,995,645**	**426,995,645**

BALANCE SHEET – NOVEMBER MONTH:

ASSETS of $2.3 billion decreased $24.1 million from October or 1.0%

- Investments decreased $193.7 million due to the timing of cash receipts and month-end requirements for operating cash
- Receivables - Other decreased $14.7 million due to timing of cash receipts
- Operating Cash increased $172.0 million due to the timing of cash receipts and disbursements
- Capitation Receivables increased $12.0 million due to the timing of cash receipts and disbursements

LIABILITIES of $1.2 billion decreased $26.4 million from October or 2.1%

- Deferred Revenue decreased $41.4 million due to timing of capitation payments from Centers for Medicare & Medicaid Services (CMS)
- Accounts Payable decreased $25.4 million due to payment of Managed Care Organization (MCO) tax
- Claims Liabilities increased $37.5 million due to timing of claim payment and changes in Incurred But Not Reported (IBNR)

NET ASSETS of $1.0 billion, increased $2.2 million from October or 0.2%

Summary of Homeless Health Initiatives and Allocated Funds
As of 11/30/2020

			Amount
Program Commitment		**$**	**100,000,000.00**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Housing Supportive Services	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,231,087		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000		
Funds Allocation Total		**$**	**42,801,087.00**
Program Commitment Balance, available for new initiatives*		**$**	**57,198,913.00**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

Budget Allocation Changes
Reporting Changes for November 2020

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Maintenance HW/SW – Corporate Application SW - LexisNexis	Maintenance HW/SW – HR Corporate Application SW - SilkRoad	$12,000	To repurpose funds from LexisNexis renewal to fund shortages in SilkRoad renewal and additional licenses	2021
October	Medi-Cal	Maintenance HW/SW - UPS Maintenance	Maintenance HW/SW - Desktop - Adobe Acrobat	$35,000	To repurpose funds from UPS Maintenance to fund shortages in Desktop - Adobe Acrobat	2021
October	Medi-Cal	Maintenance HW/SW - Microsoft True-Up	Maintenance HW/SW - Desktop - Microsoft Enterprise License Agreement	$91,000	To repurpose funds from Microsoft License True-Up to fund shortages in the new 3-year Microsoft Enterprise License Agreement	2021
November	Medi-Cal	Business Integration - Temporary Help	Process Excellence - Temporary Help	$43,000	To reallocate funds from Business Integration - Temporary Help to Process Excellence - Temporary Help for an Analyst.	2021

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

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CalOptima

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Financial Summary

December 31, 2020

Board of Directors Meeting

February 4, 2021

Nancy Huang, Chief Financial Officer

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FY 2020–21: Management Summary

- Change in Net Assets (Deficit) or Surplus
  - MTD: $8.3 million, favorable to budget $13.1 million or 271.9%
  - YTD: $9.9 million, favorable to budget $18.5 million or 215.3%
- Enrollment
  - MTD: 808,290 members, favorable to budget 5,925 or 0.7%
  - YTD: 4,747,443 member months, favorable to budget 16,951 or 0.4%
- Revenue
  - MTD: $305.9 million, unfavorable to budget $20.0 million or 6.1% driven by Medi-Cal (MC) line of business (LOB):
    - $25.8 million of Proposition 56 risk corridor reserve
  - YTD: $2.0 billion, favorable to budget $38.4 million or 2.0% driven by MC LOB:
    - Fiscal Year (FY) 2019 hospital Directed Payments (DP)
    - Offset by Gross Medical Expenditures (GME) rate reduction during Bridge Period and Proposition 56 risk corridor reserve

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FY 2020–21: Management Summary (cont.)

- Medical Expenses
  - MTD: $287.2 million, favorable to budget $31.8 million or 10.0%
    - Driven by MC LOB $35.3 million favorable variance due to decreased utilization during COVID-19 pandemic and Prior Year (PY) Proposition 56 Value-Based Program (VBP) adjustment
    - Offset by OneCare Connect (OCC) LOB $3.4 million unfavorable variance
  - YTD: $1.9 billion, unfavorable to budget $24.9 million or 1.3%
    - Driven by MC LOB FY 2019 hospital DP, offset by decreased utilization during COVID-19 pandemic and PY Proposition 56 VBP adjustment for a net unfavorable variance of $11.8 million
    - OCC LOB had a net unfavorable variance of $14.2 million
- Administrative Expenses
  - MTD: $11.1 million, favorable to budget $1.8 million or 14.2%
  - YTD: $66.5 million, favorable to budget $9.8 million or 12.8%
- Net Investment & Other Income
  - MTD: $0.7 million, unfavorable to budget $0.5 million or 41.9%
  - YTD: $2.7 million, unfavorable to budget $4.8 million or 64.2%

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FY 2020–21: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 93.9%, Budget 97.9%
  - YTD: Actual 96.3% (96.1% excluding DP), Budget 96.9%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 3.6%, Budget 4.0%
  - YTD: Actual 3.4% (3.6% excluding DP), Budget 3.9%
- Balance Sheet Ratios
  - Current ratio: 1.3
  - Board-designated reserve funds level: 1.94
  - Net position: $1.0 billion, including required Tangible Net Equity (TNE) of $102.6 million

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A Public Agency

Enrollment Summary: December 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
115,418	110,974	4,444	4.0%	SPD	682,000	665,252	16,748	2.5%
505	474	31	6.5%	BCCTP	3,068	2,899	169	5.8%
293,309	313,954	(20,645)	(6.6%)	TANF Child	1,745,528	1,839,692	(94,164)	(5.1%)
100,425	94,375	6,050	6.4%	TANF Adult	586,617	553,333	33,284	6.0%
4,934	3,515	1,419	40.4%	LTC	29,239	21,060	8,179	38.8%
265,271	251,332	13,939	5.5%	MCE	1,533,002	1,481,510	51,492	3.5%
11,487	11,932	(445)	(3.7%)	WCM	68,389	71,591	(3,202)	(4.5%)
791,349	**786,556**	**4,793**	**0.6%**	**Medi-Cal Total**	**4,647,843**	**4,635,337**	**12,506**	**0.3%**
14,938	**14,001**	**937**	**6.7%**	**OneCare Connect**	**87,780**	**84,403**	**3,377**	**4.0%**
1,609	**1,378**	**231**	**16.8%**	**OneCare**	**9,503**	**8,268**	**1,235**	**14.9%**
394	**430**	**(36)**	**(8.4%)**	**PACE**	**2,317**	**2,484**	**(167)**	**(6.7%)**
808,290	**802,365**	**5,925**	**0.7%**	**CalOptima Total**	**4,747,443**	**4,730,492**	**16,951**	**0.4%**

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CalOptima
A Public Agency

Financial Highlights: December 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
808,290	802,365	5,925	0.7%	Member Months	4,747,443	4,730,492	16,951	0.4%
305,853,725	325,866,435	(20,012,710)	(6.1%)	Revenues	1,969,601,438	1,931,243,631	38,357,807	2.0%
287,175,576	318,990,379	31,814,803	10.0%	Medical Expenses	1,895,936,929	1,871,066,575	(24,870,354)	(1.3%)
11,114,603	12,947,248	1,832,645	14.2%	Administrative Expenses	66,469,820	76,251,404	9,781,584	12.8%
7,563,546	**(6,071,192)**	**13,634,738**	**224.6%**	**Operating Margin**	**7,194,689**	**(16,074,348)**	**23,269,037**	**144.8%**
726,327	1,250,000	(523,673)	(41.9%)	Non Operating Income (Loss)	2,687,690	7,500,000	(4,812,310)	(64.2%)
8,289,873	**(4,821,192)**	**13,111,065**	**271.9%**	**Change in Net Assets**	**9,882,379**	**(8,574,348)**	**18,456,727**	**215.3%**
93.9%	97.9%	4.0%		Medical Loss Ratio	96.3%	96.9%	0.6%	
3.6%	4.0%	0.3%		Administrative Loss Ratio	3.4%	3.9%	0.6%	
2.5%	(1.9%)	4.3%		Operating Margin Ratio	0.4%	(0.8%)	1.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
93.9%	97.9%	4.0%		*MLR (excluding Directed Payments)	96.1%	96.9%	0.8%	
3.6%	4.0%	0.3%		*ALR (excluding Directed Payments)	3.6%	3.9%	0.4%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

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A Public Agency

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
7.8	(4.9)	12.6	Medi-Cal	3.2	(11.3)	14.5
(0.6)	(1.3)	0.7	OCC	0.1	(6.1)	6.2
0.1	0.0	0.0	OneCare	0.7	0.3	0.4
0.3	0.1	0.2	PACE	3.3	1.1	2.2
7.6	**(6.1)**	**13.6**	**Operating**	**7.2**	**(16.1)**	**23.3**
0.7	1.3	(0.5)	Inv./Rental Inc, MCO tax	2.7	7.5	(4.8)
0.7	**1.3**	**(0.5)**	**Non-Operating**	**2.7**	**7.5**	**(4.8)**
8.3	**(4.8)**	**13.1**	**TOTAL**	**9.9**	**(8.6)**	**18.5**

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A Public Agency

Consolidated Revenue & Expenses: December 2020 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	514,591	265,271	11,487	791,349	14,938	1,609	394	808,290
REVENUES								
Capitation Revenue	139,610,224	$ 108,907,428	$ 22,243,668	$ 270,761,320	$ 29,612,806	$ 2,205,630	$ 3,273,969	$ 305,853,725
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	139,610,224	108,907,428	22,243,668	270,761,320	29,612,806	2,205,630	3,273,969	305,853,725
MEDICAL EXPENSES								
Provider Capitation	28,750,113	40,043,542	11,147,137	79,940,792	11,559,576	592,860		92,093,228
Facilities	26,029,553	24,149,918	2,099,741	52,279,212	5,969,183	591,595	334,269	59,174,259
Professional Claims	18,429,325	7,548,249	1,149,541	27,127,115	1,027,340	96,761	774,923	29,026,138
Prescription Drugs	21,016,966	26,319,002	6,254,404	53,590,371	7,257,499	670,998	306,459	61,825,327
MLTSS	30,457,991	2,605,362	1,596,007	34,659,359	1,419,872	4,309	340,047	36,423,588
Medical Management	2,400,810	1,449,075	308,632	4,158,517	1,111,795	35,902	901,260	6,207,474
Quality Incentives	853,260	521,440	34,702	1,409,401	223,320		4,925	1,637,646
Reinsurance & Other	348,271	188,959	11,102	548,332	115,500		124,084	787,916
Total Medical Expenses	128,286,289	102,825,545	22,601,267	253,713,101	28,684,085	1,992,425	2,785,966	287,175,576
Medical Loss Ratio	91.9%	94.4%	101.6%	93.7%	96.9%	90.3%	85.1%	93.9%
GROSS MARGIN	**11,323,935**	**6,081,883**	**(357,599)**	**17,048,219**	**928,721**	**213,205**	**488,003**	**18,678,149**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				7,221,427	669,523	71,536	76,348	8,038,835
Professional fees				19,243	(14,172)	6,012	123	11,207
Purchased services				928,594	76,006	9,184	26,983	1,040,767
Printing & Postage				249,946	65,613	7,688	7,702	330,949
Depreciation & Amortization				293,403			2,020	295,423
Other expenses				1,008,982	36,161		2,300	1,047,442
Indirect cost allocation & Occupancy				(434,417)	700,977	56,377	27,044	349,980
Total Administrative Expenses				9,287,177	1,534,108	150,797	142,520	11,114,603
Admin Loss Ratio				3.4%	5.2%	6.8%	4.4%	3.6%
INCOME (LOSS) FROM OPERATIONS				7,761,042	(605,387)	62,408	345,483	7,563,546
INVESTMENT INCOME								871,568
TOTAL MCO TAX				(145,251)				(145,251)
TOTAL GRANT INCOME				10				10
CHANGE IN NET ASSETS				**$ 7,615,801**	**$ (605,387)**	**$ 62,408**	**$ 345,483**	**$ 8,289,873**
BUDGETED CHANGE IN NET ASSETS				(4,870,198)	(1,328,602)	30,782	96,826	(4,821,192)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 12,485,999	$ 723,215	$ 31,626	$ 248,657	$ 13,111,065

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Consolidated Revenue & Expenses: December 2020 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	3,046,452	1,533,002	68,389	4,647,843	87,780	9,503	2,317	4,747,443
REVENUES								
Capitation Revenue	945,630,729	$ 683,696,398	$ 133,715,208	$ 1,763,042,335	$ 174,793,704	$ 12,303,356	$ 19,462,043	$ 1,969,601,438
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	945,630,729	683,696,398	133,715,208	1,763,042,335	174,793,704	12,303,356	19,462,043	1,969,601,438
MEDICAL EXPENSES								
Provider Capitation	216,867,801	259,252,735	69,388,217	545,508,754	76,014,376	3,353,727		624,876,857
Facilities	141,881,358	151,931,952	15,556,227	309,369,537	28,257,761	2,837,754	3,524,655	343,989,706
Professional Claims	115,650,031	52,286,259	6,106,468	174,042,758	5,894,089	470,148	3,732,550	184,139,545
Prescription Drugs	120,556,373	150,005,493	30,108,538	300,670,404	38,097,478	3,614,065	1,731,650	344,113,597
MLTSS	207,464,281	16,984,133	11,213,453	235,661,866	8,628,646	196,297	330,370	244,817,179
Medical Management	14,155,194	8,368,356	1,774,567	24,298,117	6,522,581	204,060	5,160,943	36,185,701
Quality Incentives	5,108,634	3,046,799	203,862	8,359,295	1,304,160		113,322	9,776,776
Reinsurance & Other	59,055,752	47,399,035	74,579	106,529,366	827,744		680,457	108,037,566
Total Medical Expenses	880,739,425	689,274,761	134,425,911	1,704,440,097	165,546,835	10,676,051	15,273,947	1,895,936,929
Medical Loss Ratio	93.1%	100.8%	100.5%	96.7%	94.7%	86.8%	78.5%	96.3%
GROSS MARGIN	**64,891,303**	**(5,578,363)**	**(710,703)**	**58,602,238**	**9,246,870**	**1,627,305**	**4,188,096**	**73,664,509**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				40,851,767	4,199,865	504,995	686,164	46,242,792
Professional fees				708,471	100,266	86,012	780	895,529
Purchased services				4,618,656	528,945	49,224	99,719	5,296,543
Printing & Postage				1,372,112	492,875	34,520	64,607	1,964,114
Depreciation & Amortization				1,759,271			12,181	1,771,452
Other expenses				7,853,530	256,098	205	17,508	8,127,340
Indirect cost allocation & Occupancy				(1,720,643)	3,594,928	253,039	44,726	2,172,050
Total Administrative Expenses				55,443,163	9,172,977	927,995	925,685	66,469,820
Admin Loss Ratio				3.1%	5.2%	7.5%	4.8%	3.4%
INCOME (LOSS) FROM OPERATIONS				3,159,075	73,893	699,310	3,262,411	7,194,689
INVESTMENT INCOME								5,087,140
TOTAL MCO TAX				(2,435,277)				(2,435,277)
TOTAL GRANT INCOME				35,513				35,513
OTHER INCOME				315				315
CHANGE IN NET ASSETS				**$ 759,625**	**$ 73,893**	**$ 699,310**	**$ 3,262,411**	**$ 9,882,379**
BUDGETED CHANGE IN NET ASSETS				(11,329,620)	(6,093,498)	291,627	1,057,143	(8,574,348)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 12,089,245	$ 6,167,391	$ 407,683	$ 2,205,268	$ 18,456,727

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CalOptima
A Public Agency

Balance Sheet: As of December 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$410,226,522	Accounts Payable	$45,070,735
Investments	771,982,646	Medical Claims liability	975,548,407
Capitation receivable	354,539,870	Accrued Payroll Liabilities	14,952,089
Receivables - Other	40,259,446	Deferred Revenue	19,607,055
Prepaid expenses	6,889,439	Deferred Lease Obligations	144,282
		Capitation and Withholds	138,487,234
Total Current Assets	**1,583,897,923**	**Total Current Liabilities**	**1,193,809,802**
Capital Assets			
Furniture & Equipment	40,923,636		
Building/Leasehold Improvements	11,011,151		
505 City Parkway West	51,628,218		
	103,563,004		
Less: accumulated depreciation	(56,383,869)		
Capital assets, net	47,179,135	Other (than pensions) post employment benefits liability	26,104,933
Other Assets		Net Pension Liabilities	27,210,891
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	57,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,247,125,626**
Cash and Cash Equivalents	2,174,904		
Long-term Investments	586,404,630	**Deferred Inflows**	
Total Board-designated Assets	588,579,534	Excess Earnings	506,547
		OPEB 75 Difference in Experience	804,000
		Change in Assumptions	3,728,725
Total Other Assets	646,078,447	OPEB Changes in Assumptions	1,638,000
		Net Position	
TOTAL ASSETS	**2,277,155,504**	TNE	102,638,683
Deferred Outflows		Funds in Excess of TNE	932,374,993
Contributions	1,047,297	**TOTAL NET POSITION**	1,035,013,676
Difference in Experience	4,280,308		
Excess Earning	-		
Changes in Assumptions	5,060,465		
OPEB 75 Changes in Assumptions	703,000		
Pension Contributions	570,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,288,816,574**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,288,816,574**

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Board Designated Reserve and TNE Analysis: As of December 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,998,073				
	Tier 1 - MetLife	159,847,291				
	Tier 1 - Wells Capital	160,108,714				
Board-designated Reserve		480,954,078	322,707,512	504,998,739	158,246,566	(24,044,661)
TNE Requirement	Tier 2 - MetLife	107,625,455	102,638,683	102,638,683	4,986,773	4,986,773
	Consolidated:	**588,579,534**	**425,346,195**	**607,637,422**	**163,233,338**	**(19,057,888)**
	Current reserve level	*1.94*	*1.40*	*2.00*		

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CalOptima
A Public Agency

Our Mission

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

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CalOptima
A Public Agency

UNAUDITED FINANCIAL STATEMENTS

December 31, 2020

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CalOptima - Consolidated
Financial Highlights
For the Six Months Ended December 31, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
808,290	802,365	5,925	0.7%	Member Months	4,747,443	4,730,492	16,951	0.4%
305,853,725	325,866,435	(20,012,710)	(6.1%)	Revenues	1,969,601,438	1,931,243,631	38,357,807	2.0%
287,175,576	318,990,379	31,814,803	10.0%	Medical Expenses	1,895,936,929	1,871,066,575	(24,870,354)	(1.3%)
11,114,603	12,947,248	1,832,645	14.2%	Administrative Expenses	66,469,820	76,251,404	9,781,584	12.8%
7,563,546	**(6,071,192)**	**13,634,738**	**224.6%**	**Operating Margin**	**7,194,689**	**(16,074,348)**	**23,269,037**	**144.8%**
726,327	1,250,000	(523,673)	(41.9%)	Non Operating Income (Loss)	2,687,690	7,500,000	(4,812,310)	(64.2%)
8,289,873	**(4,821,192)**	**13,111,065**	**271.9%**	**Change in Net Assets**	**9,882,379**	**(8,574,348)**	**18,456,727**	**215.3%**
93.9%	97.9%	4.0%		Medical Loss Ratio	96.3%	96.9%	0.6%	
3.6%	4.0%	0.3%		Administrative Loss Ratio	3.4%	3.9%	0.6%	
2.5%	(1.9%)	4.3%		Operating Margin Ratio	0.4%	(0.8%)	1.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
93.9%	97.9%	4.0%		*MLR (excluding Directed Payments)	96.1%	96.9%	0.8%	
3.6%	4.0%	0.3%		*ALR (excluding Directed Payments)	3.6%	3.9%	0.4%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Six Months Ended December 31, 2020

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	791,349	786,556	4,793	0.6%
OneCare Connect	14,938	14,001	937	6.7%
OneCare	1,609	1,378	231	16.8%
PACE	394	430	(36)	(8.4%)
Total	808,290	802,365	5,925	0.7%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 7,616	$ (4,870)	$ 12,486	256.4%
OneCare Connect	(605)	(1,329)	723	54.4%
OneCare	62	31	32	102.7%
PACE	345	97	249	256.8%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	872	1,250	(378)	(30.2%)
Total	$ 8,290	$ (4,821)	$ 13,111	272.0%

MLR

	Actual	Budget	% Point Var
Medi-Cal	93.7%	97.9%	4.2
OneCare Connect	96.9%	98.8%	2.0
OneCare	90.3%	89.9%	(0.4)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,287	$ 10,978	$ 1,691	15.4%
OneCare Connect	1,534	1,630	95	5.9%
OneCare	151	138	(13)	(9.1%)
PACE	143	201	59	29.2%
Total	$ 11,115	$ 12,947	$ 1,833	14.2%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,074	1,161	87
OneCare Connect	185	210	24
OneCare	10	9	(1)
PACE	92	116	24
Total	1,362	1,496	134

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	737	678	59
OneCare Connect	81	67	14
OneCare	161	148	13
PACE	4	4	1
Total	983	896	86

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	4,647,843	4,635,337	12,506	0.3%
OneCare Connect	87,780	84,403	3,377	4.0%
OneCare	9,503	8,268	1,235	14.9%
PACE	2,317	2,484	(167)	(6.7%)
Total	4,747,443	4,730,492	16,951	0.4%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 760	$ (11,330)	$ 12,089	106.7%
OneCare Connect	74	(6,093)	6,167	101.2%
OneCare	699	292	408	139.8%
PACE	3,262	1,057	2,205	208.6%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	5,087	7,500	(2,413)	(32.2%)
Total	$ 9,882	$ (8,574)	$ 18,456	215.3%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.7%	96.9%	0.3
OneCare Connect	94.7%	97.7%	3.0
OneCare	86.8%	89.0%	2.2

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 55,443	$ 64,725	$ 9,282	14.3%
OneCare Connect	9,173	9,667	494	5.1%
OneCare	928	822	(106)	(12.9%)
PACE	926	1,038	112	10.8%
Total	$ 66,470	$ 76,251	$ 9,782	12.8%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	6,494	6,965	470
OneCare Connect	1,137	1,259	121
OneCare	61	56	(5)
PACE	545	698	153
Total	8,238	8,977	739

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	716	666	50
OneCare Connect	77	67	10
OneCare	156	148	8
PACE	4	4	1
Total	954	884	69

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

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	808,290		802,365		5,925	
REVENUE						
Medi-Cal	$ 270,761,320	$ 342.15	$ 295,099,667	$ 375.18	$ (24,338,347)	$ (33.03)
OneCare Connect	29,612,806	1,982.38	25,598,552	1,828.34	4,014,254	154.04
OneCare	2,205,630	1,370.81	1,678,387	1,217.99	527,243	152.82
PACE	3,273,969	8,309.57	3,489,829	8,115.88	(215,860)	193.69
Total Operating Revenue	305,853,725	378.40	325,866,435	406.13	(20,012,710)	(27.73)
MEDICAL EXPENSES						
Medi-Cal	253,713,101	320.61	288,991,651	367.41	35,278,550	46.80
OneCare Connect	28,684,085	1,920.21	25,297,628	1,806.84	(3,386,457)	(113.37)
OneCare	1,992,425	1,238.30	1,509,343	1,095.31	(483,082)	(142.99)
PACE	2,785,966	7,070.98	3,191,757	7,422.69	405,791	351.71
Total Medical Expenses	287,175,576	355.29	318,990,379	397.56	31,814,803	42.27
GROSS MARGIN	18,678,149	23.11	6,876,056	8.57	11,802,093	14.54
ADMINISTRATIVE EXPENSES						
Salaries and benefits	8,038,835	9.95	8,158,058	10.17	119,223	0.22
Professional fees	11,207	0.01	376,770	0.47	365,563	0.46
Purchased services	1,040,767	1.29	1,295,326	1.61	254,559	0.32
Printing & Postage	330,949	0.41	575,359	0.72	244,410	0.31
Depreciation & Amortization	295,423	0.37	460,570	0.57	165,147	0.20
Other expenses	1,047,442	1.30	1,699,365	2.12	651,923	0.82
Indirect cost allocation & Occupancy expense	349,980	0.43	381,800	0.48	31,820	0.05
Total Administrative Expenses	11,114,603	13.75	12,947,248	16.14	1,832,645	2.39
INCOME (LOSS) FROM OPERATIONS	7,563,546	9.36	(6,071,192)	(7.57)	13,634,738	16.93
INVESTMENT INCOME						
Interest income	850,703	1.05	1,250,000	1.56	(399,297)	(0.51)
Realized gain/(loss) on investments	289,561	0.36	-	-	289,561	0.36
Unrealized gain/(loss) on investments	(268,697)	(0.33)	-	-	(268,697)	(0.33)
Total Investment Income	871,568	1.08	1,250,000	1.56	(378,432)	(0.48)
TOTAL MCO TAX	(145,251)	(0.18)	-	-	(145,251)	(0.18)
TOTAL GRANT INCOME	10	-	-	-	10	-
CHANGE IN NET ASSETS	**8,289,873**	**10.26**	**(4,821,192)**	**(6.01)**	**13,111,065**	**16.27**
MEDICAL LOSS RATIO	**93.9%**		**97.9%**		**4.0%**	
ADMINISTRATIVE LOSS RATIO	**3.6%**		**4.0%**		**0.3%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Six Months Ended December 31, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	4,747,443		4,730,492		16,951	
REVENUE						
Medi-Cal	$ 1,763,042,335	$ 379.32	$ 1,746,059,715	$ 376.68	$ 16,982,620	$ 2.64
OneCare Connect	174,793,704	1,991.27	154,890,301	1,835.13	19,903,403	156.14
OneCare	12,303,356	1,294.68	10,111,444	1,222.96	2,191,912	71.72
PACE	19,462,043	8,399.67	20,182,171	8,124.87	(720,128)	274.80
Total Operating Revenue	1,969,601,438	414.88	1,931,243,631	408.25	38,357,807	6.63
MEDICAL EXPENSES						
Medi-Cal	1,704,440,097	366.72	1,692,664,531	365.17	(11,775,566)	(1.55)
OneCare Connect	165,546,835	1,885.93	151,317,061	1,792.79	(14,229,774)	(93.14)
OneCare	10,676,051	1,123.44	8,997,556	1,088.24	(1,678,495)	(35.20)
PACE	15,273,947	6,592.12	18,087,427	7,281.57	2,813,480	689.45
Total Medical Expenses	1,895,936,929	399.36	1,871,066,575	395.53	(24,870,354)	(3.83)
GROSS MARGIN	73,664,509	15.52	60,177,056	12.72	13,487,453	2.80
ADMINISTRATIVE EXPENSES						
Salaries and benefits	46,242,792	9.74	47,661,788	10.08	1,418,996	0.34
Professional fees	895,529	0.19	2,223,480	0.47	1,327,951	0.28
Purchased services	5,296,543	1.12	7,695,707	1.63	2,399,164	0.51
Printing & Postage	1,964,114	0.41	3,429,654	0.73	1,465,540	0.32
Depreciation & Amortization	1,771,452	0.37	2,763,420	0.58	991,968	0.21
Other expenses	8,127,340	1.71	10,172,024	2.15	2,044,684	0.44
Indirect cost allocation & Occupancy expense	2,172,050	0.46	2,305,331	0.49	133,281	0.03
Total Administrative Expenses	66,469,820	14.00	76,251,404	16.12	9,781,584	2.12
INCOME (LOSS) FROM OPERATIONS	7,194,689	1.52	(16,074,348)	(3.40)	23,269,037	4.92
INVESTMENT INCOME						
Interest income	6,481,261	1.37	7,500,000	1.59	(1,018,739)	(0.22)
Realized gain/(loss) on investments	3,598,441	0.76	-	-	3,598,441	0.76
Unrealized gain/(loss) on investments	(4,992,563)	(1.05)	-	-	(4,992,563)	(1.05)
Total Investment Income	5,087,140	1.07	7,500,000	1.59	(2,412,860)	(0.52)
TOTAL MCO TAX	(2,435,277)	(0.51)	-	-	(2,435,277)	(0.51)
TOTAL GRANT INCOME	35,513	0.01	-	-	35,513	0.01
OTHER INCOME	315	-	-	-	315	-
CHANGE IN NET ASSETS	**9,882,379**	**2.08**	**(8,574,348)**	**(1.81)**	**18,456,727**	**3.89**
MEDICAL LOSS RATIO	**96.3%**		**96.9%**		**0.6%**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**3.9%**		**0.6%**	

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

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	514,591	265,271	11,487	791,349	14,938	1,609	394	808,290
REVENUES								
Capitation Revenue	139,610,224	$ 108,907,428	$ 22,243,668	$ 270,761,320	$ 29,612,806	$ 2,205,630	$ 3,273,969	$ 305,853,725
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	139,610,224	108,907,428	22,243,668	270,761,320	29,612,806	2,205,630	3,273,969	305,853,725
MEDICAL EXPENSES								
Provider Capitation	28,750,113	40,043,542	11,147,137	79,940,792	11,559,576	592,860		92,093,228
Facilities	26,029,553	24,149,918	2,099,741	52,279,212	5,969,183	591,595	334,269	59,174,259
Professional Claims	18,429,325	7,548,249	1,149,541	27,127,115	1,027,340	96,761	774,923	29,026,138
Prescription Drugs	21,016,966	26,319,002	6,254,404	53,590,371	7,257,499	670,998	306,459	61,825,327
MLTSS	30,457,991	2,605,362	1,596,007	34,659,359	1,419,872	4,309	340,047	36,423,588
Medical Management	2,400,810	1,449,075	308,632	4,158,517	1,111,795	35,902	901,260	6,207,474
Quality Incentives	853,260	521,440	34,702	1,409,401	223,320		4,925	1,637,646
Reinsurance & Other	348,271	188,959	11,102	548,332	115,500		124,084	787,916
Total Medical Expenses	128,286,289	102,825,545	22,601,267	253,713,101	28,684,085	1,992,425	2,785,966	287,175,576
Medical Loss Ratio	91.9%	94.4%	101.6%	93.7%	96.9%	90.3%	85.1%	93.9%
GROSS MARGIN	**11,323,935**	**6,081,883**	**(357,599)**	**17,048,219**	**928,721**	**213,205**	**488,003**	**18,678,149**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				7,221,427	669,523	71,536	76,348	8,038,835
Professional fees				19,243	(14,172)	6,012	123	11,207
Purchased services				928,594	76,006	9,184	26,983	1,040,767
Printing & Postage				249,946	65,613	7,688	7,702	330,949
Depreciation & Amortization				293,403			2,020	295,423
Other expenses				1,008,982	36,161		2,300	1,047,442
Indirect cost allocation & Occupancy				(434,417)	700,977	56,377	27,044	349,980
Total Administrative Expenses				9,287,177	1,534,108	150,797	142,520	11,114,603
Admin Loss Ratio				3.4%	5.2%	6.8%	4.4%	3.6%
INCOME (LOSS) FROM OPERATIONS				7,761,042	(605,387)	62,408	345,483	7,563,546
INVESTMENT INCOME								871,568
TOTAL MCO TAX				(145,251)				(145,251)
TOTAL GRANT INCOME				10				10
CHANGE IN NET ASSETS				**$ 7,615,801**	**$ (605,387)**	**$ 62,408**	**$ 345,483**	**$ 8,289,873**
BUDGETED CHANGE IN NET ASSETS				(4,870,198)	(1,328,602)	30,782	96,826	(4,821,192)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 12,485,999	$ 723,215	$ 31,626	$ 248,657	$ 13,111,065

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

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	3,046,452	1,533,002	68,389	4,647,843	87,780	9,503	2,317	4,747,443
REVENUES								
Capitation Revenue	945,630,729	$ 683,696,398	$ 133,715,208	$ 1,763,042,335	$ 174,793,704	$ 12,303,356	$ 19,462,043	$ 1,969,601,438
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	945,630,729	683,696,398	133,715,208	1,763,042,335	174,793,704	12,303,356	19,462,043	1,969,601,438
MEDICAL EXPENSES								
Provider Capitation	216,867,801	259,252,735	69,388,217	545,508,754	76,014,376	3,353,727		624,876,857
Facilities	141,881,358	151,931,952	15,556,227	309,369,537	28,257,761	2,837,754	3,524,655	343,989,706
Professional Claims	115,650,031	52,286,259	6,106,468	174,042,758	5,894,089	470,148	3,732,550	184,139,545
Prescription Drugs	120,556,373	150,005,493	30,108,538	300,670,404	38,097,478	3,614,065	1,731,650	344,113,597
MLTSS	207,464,281	16,984,133	11,213,453	235,661,866	8,628,646	196,297	330,370	244,817,179
Medical Management	14,155,194	8,368,356	1,774,567	24,298,117	6,522,581	204,060	5,160,943	36,185,701
Quality Incentives	5,108,634	3,046,799	203,862	8,359,295	1,304,160		113,322	9,776,776
Reinsurance & Other	59,055,752	47,399,035	74,579	106,529,366	827,744		680,457	108,037,566
Total Medical Expenses	880,739,425	689,274,761	134,425,911	1,704,440,097	165,546,835	10,676,051	15,273,947	1,895,936,929
Medical Loss Ratio	93.1%	100.8%	100.5%	96.7%	94.7%	86.8%	78.5%	96.3%
GROSS MARGIN	**64,891,303**	**(5,578,363)**	**(710,703)**	**58,602,238**	**9,246,870**	**1,627,305**	**4,188,096**	**73,664,509**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				40,851,767	4,199,865	504,995	686,164	46,242,792
Professional fees				708,471	100,266	86,012	780	895,529
Purchased services				4,618,656	528,945	49,224	99,719	5,296,543
Printing & Postage				1,372,112	492,875	34,520	64,607	1,964,114
Depreciation & Amortization				1,759,271			12,181	1,771,452
Other expenses				7,853,530	256,098	205	17,508	8,127,340
Indirect cost allocation & Occupancy				(1,720,643)	3,594,928	253,039	44,726	2,172,050
Total Administrative Expenses				55,443,163	9,172,977	927,995	925,685	66,469,820
Admin Loss Ratio				3.1%	5.2%	7.5%	4.8%	3.4%
INCOME (LOSS) FROM OPERATIONS				3,159,075	73,893	699,310	3,262,411	7,194,689
INVESTMENT INCOME								5,087,140
TOTAL MCO TAX				(2,435,277)				(2,435,277)
TOTAL GRANT INCOME				35,513				35,513
OTHER INCOME				315				315
CHANGE IN NET ASSETS				**$ 759,625**	**$ 73,893**	**$ 699,310**	**$ 3,262,411**	**$ 9,882,379**
BUDGETED CHANGE IN NET ASSETS				(11,329,620)	(6,093,498)	291,627	1,057,143	(8,574,348)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 12,089,245	$ 6,167,391	$ 407,683	$ 2,205,268	$ 18,456,727

December 31, 2020 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $8.3 million, $13.1 million favorable to budget
- Operating surplus is $7.6 million, with a surplus in non-operating income of $0.7 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $9.9 million, $18.5 million favorable to budget
- Operating surplus is $7.2 million, with a surplus in non-operating income of $2.7 million

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
7.8	(4.9)	12.6	Medi-Cal	3.2	(11.3)	14.5
(0.6)	(1.3)	0.7	OCC	0.1	(6.1)	6.2
0.1	0.0	0.0	OneCare	0.7	0.3	0.4
0.3	0.1	0.2	PACE	3.3	1.1	2.2
7.6	**(6.1)**	**13.6**	**Operating**	**7.2**	**(16.1)**	**23.3**
0.7	1.3	(0.5)	Inv./Rental Inc, MCO tax	2.7	7.5	(4.8)
0.7	**1.3**	**(0.5)**	**Non-Operating**	**2.7**	**7.5**	**(4.8)**
8.3	**(4.8)**	**13.1**	**TOTAL**	**9.9**	**(8.6)**	**18.5**

CalOptima - Consolidated
Enrollment Summary
For the Six Months Ended December 31, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
115,418	110,974	4,444	4.0%	SPD	682,000	665,252	16,748	2.5%
505	474	31	6.5%	BCCTP	3,068	2,899	169	5.8%
293,309	313,954	(20,645)	(6.6%)	TANF Child	1,745,528	1,839,692	(94,164)	(5.1%)
100,425	94,375	6,050	6.4%	TANF Adult	586,617	553,333	33,284	6.0%
4,934	3,515	1,419	40.4%	LTC	29,239	21,060	8,179	38.8%
265,271	251,332	13,939	5.5%	MCE	1,533,002	1,481,510	51,492	3.5%
11,487	11,932	(445)	(3.7%)	WCM	68,389	71,591	(3,202)	(4.5%)
791,349	**786,556**	**4,793**	**0.6%**	**Medi-Cal Total**	**4,647,843**	**4,635,337**	**12,506**	**0.3%**
14,938	**14,001**	**937**	**6.7%**	**OneCare Connect**	**87,780**	**84,403**	**3,377**	**4.0%**
1,609	**1,378**	**231**	**16.8%**	**OneCare**	**9,503**	**8,268**	**1,235**	**14.9%**
394	**430**	**(36)**	**(8.4%)**	**PACE**	**2,317**	**2,484**	**(167)**	**(6.7%)**
808,290	**802,365**	**5,925**	**0.7%**	**CalOptima Total**	**4,747,443**	**4,730,492**	**16,951**	**0.4%**
				Enrollment (by Network)				
181,423	174,882	6,541	3.7%	HMO	1,056,353	1,033,426	22,927	2.2%
221,693	227,083	(5,390)	(2.4%)	PHC	1,308,711	1,336,993	(28,282)	(2.1%)
192,158	194,655	(2,497)	(1.3%)	Shared Risk Group	1,118,956	1,136,052	(17,096)	(1.5%)
196,075	189,936	6,139	3.2%	Fee for Service	1,163,823	1,128,866	34,957	3.1%
791,349	**786,556**	**4,793**	**0.6%**	**Medi-Cal Total**	**4,647,843**	**4,635,337**	**12,506**	**0.3%**
14,938	**14,001**	**937**	**6.7%**	**OneCare Connect**	**87,780**	**84,403**	**3,377**	**4.0%**
1,609	**1,378**	**231**	**16.8%**	**OneCare**	**9,503**	**8,268**	**1,235**	**14.9%**
394	**430**	**(36)**	**(8.4%)**	**PACE**	**2,317**	**2,484**	**(167)**	**(6.7%)**
808,290	**802,365**	**5,925**	**0.7%**	**CalOptima Total**	**4,747,443**	**4,730,492**	**16,951**	**0.4%**

CalOptima
Enrollment Trend by Network
Fiscal Year 2021

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,536	10,583	10,588	10,639	10,658	10,725							63,729	62,121	1,608
BCCTP	1	1	1	1	1	1							6	6	0
TANF Child	54,644	55,088	55,115	55,276	55,934	56,264							332,321	346,346	(14,025)
TANF Adult	29,033	29,687	30,001	30,679	30,990	31,336							181,726	174,640	7,086
LTC	(1)	402	197	215	239	238							1,290	12	1,278
MCE	74,441	75,955	76,054	78,435	79,490	80,792							465,167	438,031	27,136
WCM	1,721	1,726	2,086	2,507	2,007	2,067							12,114	12,270	(156)
Total	**170,375**	**173,442**	**174,042**	**177,752**	**179,319**	**181,423**							**1,056,353**	**1,033,426**	**22,927**
PHCs															
SPD	7,145	7,205	6,855	6,760	7,010	7,042							42,017	42,134	(117)
BCCTP													-		0
TANF Child	149,810	151,008	148,874	150,336	152,122	152,428							904,578	948,107	(43,529)
TANF Adult	11,688	12,097	12,071	12,492	12,728	12,694							73,770	68,898	4,872
LTC		158	81	65	76	80							460	6	454
MCE	39,815	40,711	39,935	41,371	41,820	42,350							246,002	234,749	11,253
WCM	5,625	5,716	7,990	8,497	6,957	7,099							41,884	43,099	(1,215)
Total	**214,083**	**216,895**	**215,806**	**219,521**	**220,713**	**221,693**							**1,308,711**	**1,336,993**	**(28,282)**
Shared Risk Groups															
SPD	10,264	10,312	10,068	10,117	10,120	10,261							61,142	60,733	409
BCCTP													-		0
TANF Child	58,289	58,687	57,269	58,133	58,881	58,952							350,211	384,201	(33,990)
TANF Adult	28,914	29,648	29,235	30,414	30,910	31,050							180,171	176,127	4,044
LTC	1	365	178	209	217	219							1,189	12	1,177
MCE	82,747	84,907	83,063	87,432	88,969	90,268							517,386	504,823	12,563
WCM	924	1,000	1,954	2,189	1,382	1,408							8,857	10,156	(1,299)
Total	**181,139**	**184,919**	**181,767**	**188,494**	**190,479**	**192,158**							**1,118,956**	**1,136,052**	**(17,096)**
Fee for Service (Dual)															
SPD	74,615	75,198	75,269	76,815	76,628	77,616							456,141	441,023	15,118
BCCTP	12	17	18	18	14	14							93	102	(9)
TANF Child	1	1	1	1	1	1							6	13	(7)
TANF Adult	909	1,266	994	1,107	1,015	1,030							6,321	5,914	407
LTC	3,079	4,461	3,855	3,838	3,818	3,817							22,868	18,972	3,896
MCE	1,658	1,859	1,948	2,077	2,138	2,334							12,014	8,945	3,069
WCM	13	17	16	17	15	14							92	78	14
Total	**80,287**	**82,819**	**82,101**	**83,873**	**83,629**	**84,826**							**497,535**	**475,047**	**22,488**
Fee for Service (Non-Dual - Total)															
SPD	9,830	9,822	10,264	9,977	9,304	9,774							58,971	59,241	(270)
BCCTP	497	492	499	506	485	490							2,969	2,791	178
TANF Child	25,494	27,007	28,092	26,150	26,005	25,664							158,412	161,025	(2,613)
TANF Adult	23,028	24,014	24,847	24,196	24,229	24,315							144,629	127,754	16,875
LTC	351	788	580	573	560	580							3,432	2,058	1,374
MCE	45,498	47,292	52,445	48,625	49,046	49,527							292,433	294,962	(2,529)
WCM	791	806	974	1,076	896	899							5,442	5,988	(546)
Total	**105,489**	**110,221**	**117,701**	**111,103**	**110,525**	**111,249**							**666,288**	**653,819**	**12,469**
SPD	112,390	113,120	113,044	114,308	113,720	115,418							682,000	665,252	16,748
BCCTP	510	510	518	525	500	505							3,068	2,899	169
TANF Child	288,238	291,791	289,351	289,896	292,943	293,309							1,745,528	1,839,692	(94,164)
TANF Adult	93,572	96,712	97,148	98,888	99,872	100,425							586,617	553,333	33,284
LTC	3,430	6,174	4,891	4,900	4,910	4,934							29,239	21,060	8,179
MCE	244,159	250,724	253,445	257,940	261,463	265,271							1,533,002	1,481,510	51,492
WCM	9,074	9,265	13,020	14,286	11,257	11,487							68,389	71,591	(3,202)
Total Medi-Cal MM	**751,373**	**768,296**	**771,417**	**780,743**	**784,665**	**791,349**							**4,647,843**	**4,635,337**	**12,506**
OneCare Connect	**14,465**	**14,541**	**14,529**	**14,720**	**14,587**	**14,938**							**87,780**	**84,403**	**3,377**
OneCare	**1,525**	**1,523**	**1,594**	**1,627**	**1,625**	**1,609**							**9,503**	**8,268**	**1,235**
PACE	**382**	**381**	**380**	**387**	**393**	**394**							**2,317**	**2,484**	**(167)**
Grand Total	**767,745**	**784,741**	**787,920**	**797,477**	**801,270**	**808,290**							**4,747,443**	**4,730,492**	**16,951**

ENROLLMENT:

Overall, December enrollment was 808,290

- Favorable to budget 5,925 or 0.7%
- Increased 7,020 or 0.9% from prior month (PM) (November 2020)
- Increased 69,755 or 9.4% from prior year (PY) (December 2019)

Medi-Cal enrollment was 791,349

- Favorable to budget 4,793 or 0.6%
  - Medi-Cal Expansion (MCE) favorable 13,939
  - Seniors and Persons with Disabilities (SPD) favorable 4,444
  - Long-Term Care (LTC) favorable 1,419
  - Breast and Cervical Cancer Treatment Program (BCCTP) favorable 31
  - Temporary Assistance for Needy Families (TANF) unfavorable 14,595
  - Whole Child Model (WCM) unfavorable 445
- Increased 6,684 from PM

OneCare Connect enrollment was 14,938

- Favorable to budget 937 or 6.7%
- Increased 351 from PM

OneCare enrollment was 1,609

- Favorable to budget 231 or 16.8%
- Decreased 16 from PM

PACE enrollment was 394

- Unfavorable to budget 36 or 8.4%
- Increased 1 from PM

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

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
791,349	**786,556**	**4,793**	**0.6%**	**Member Months**	**4,647,843**	**4,635,337**	**12,506**	**0.3%**
				Revenues				
270,761,320	295,099,667	(24,338,347)	(8.2%)	Capitation Revenue	1,763,042,335	1,746,059,715	16,982,620	1.0%
-	-	-	0.0%	Other Income	-	-	-	0.0%
270,761,320	**295,099,667**	**(24,338,347)**	**(8.2%)**	**Total Operating Revenue**	**1,763,042,335**	**1,746,059,715**	**16,982,620**	**1.0%**
				Medical Expenses				
81,350,194	99,976,205	18,626,011	18.6%	Provider Capitation	553,868,049	589,851,059	35,983,010	6.1%
52,279,212	59,972,101	7,692,889	12.8%	Facilities Claims	309,369,537	348,989,118	39,619,581	11.4%
27,127,115	33,763,758	6,636,643	19.7%	Professional Claims	174,042,758	197,315,864	23,273,106	11.8%
53,590,371	48,331,371	(5,259,000)	(10.9%)	Prescription Drugs	300,670,404	280,984,863	(19,685,541)	(7.0%)
34,659,359	41,022,540	6,363,181	15.5%	MLTSS	235,661,866	242,131,481	6,469,615	2.7%
4,158,517	5,321,666	1,163,149	21.9%	Medical Management	24,298,117	29,768,104	5,469,987	18.4%
548,332	604,010	55,678	9.2%	Reinsurance & Other	106,529,366	3,624,042	(102,905,324)	(2839.5%)
253,713,101	**288,991,651**	**35,278,550**	**12.2%**	**Total Medical Expenses**	**1,704,440,097**	**1,692,664,531**	**(11,775,566)**	**(0.7%)**
17,048,219	**6,108,016**	**10,940,203**	**179.1%**	**Gross Margin**	**58,602,238**	**53,395,184**	**5,207,054**	**9.8%**
				Administrative Expenses				
7,221,427	7,146,271	(75,156)	(1.1%)	Salaries, Wages & Employee Benefits	40,851,767	41,766,177	914,410	2.2%
19,243	320,521	301,278	94.0%	Professional Fees	708,471	1,885,986	1,177,515	62.4%
928,594	1,142,513	213,919	18.7%	Purchased Services	4,618,656	6,866,329	2,247,673	32.7%
249,946	443,433	193,487	43.6%	Printing and Postage	1,372,112	2,660,598	1,288,486	48.4%
293,403	458,500	165,097	36.0%	Depreciation & Amortization	1,759,271	2,751,000	991,729	36.0%
1,008,982	1,678,430	669,448	39.9%	Other Operating Expenses	7,853,530	10,048,306	2,194,776	21.8%
(434,417)	(211,454)	222,963	105.4%	Indirect Cost Allocation, Occupancy Expense	(1,720,643)	(1,253,592)	467,051	37.3%
9,287,177	**10,978,214**	**1,691,037**	**15.4%**	**Total Administrative Expenses**	**55,443,163**	**64,724,804**	**9,281,641**	**14.3%**
				Operating Tax				
12,323,499	15,227,150	(2,903,651)	(19.1%)	Tax Revenue	72,377,223	89,761,077	(17,383,854)	(19.4%)
12,468,750	15,227,150	2,758,400	18.1%	Premium Tax Expense	74,812,500	89,761,077	14,948,577	16.7%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
(145,251)	-	(145,251)	**0.0%**	**Total Net Operating Tax**	(2,435,277)	-	(2,435,277)	**0.0%**
				Grant Income				
5,644	-	5,644	0.0%	Grant Revenue	268,866	-	268,866	0.0%
(10)	-	10	0.0%	Grant expense - Service Partner	201,238	-	(201,238)	0.0%
5,644	-	(5,644)	0.0%	Grant expense - Administrative	32,116	-	(32,116)	0.0%
10	-	10	**0.0%**	**Total Grant Income**	35,513	-	35,513	**0.0%**
-	**-**	**-**	**0.0%**	**Other income**	**315**	**-**	**315**	**0.0%**
7,615,801	**(4,870,198)**	**12,485,999**	**256.4%**	**Change in Net Assets**	**759,625**	**(11,329,620)**	**12,089,245**	**106.7%**
93.7%	***97.9%***	***4.2%***	***4.3%***	***Medical Loss Ratio***	***96.7%***	***96.9%***	***0.3%***	***0.3%***
3.4%	***3.7%***	***0.3%***	***7.8%***	***Admin Loss Ratio***	***3.1%***	***3.7%***	***0.6%***	***15.2%***

MEDI-CAL INCOME STATEMENT– DECEMBER MONTH:

REVENUES of $270.8 million are unfavorable to budget $24.3 million driven by:

- Favorable volume related variance of $1.8 million
- Unfavorable price related variance of $26.1 million
  - $25.8 million of Proposition 56 risk corridor reserve

MEDICAL EXPENSES of $253.7 million are favorable to budget $35.3 million driven by:

- Unfavorable volume related variance of $1.8 million
- Favorable price related variance of $37.0 million
  - Provider Capitation expense favorable variance of $19.2 million due to adjustment for PY Proposition 56 Value-Based Program (VBP) adjustment
  - Facilities Claims expense favorable variance of $8.1 million due to decreased utilization during COVID-19 pandemic
  - Professional Claims expense favorable variance of $6.8 million due to decreased utilization during COVID-19 pandemic
  - Managed Long Term Services and Supports (MLTSS) expense favorable variance of $6.6 million due to claims Incurred But Not Reported (IBNR)
  - Medical Management expense favorable variance of $1.2 million
  - Offset by Prescription Drugs expense unfavorable variance of $5.0 million

ADMINISTRATIVE EXPENSES of $9.3 million are favorable to budget $1.7 million driven by:

- Other Non-Salary expense favorable to budget $1.8 million
- Salaries & Benefit expense unfavorable to budget $0.1 million

CHANGE IN NET ASSETS is $7.6 million for the month, favorable to budget $12.5 million

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

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,938	**14,001**	**937**	**6.7%**	**Member Months**	**87,780**	**84,403**	**3,377**	**4.0%**
				Revenues				
2,930,253	2,702,723	227,530	8.4%	Medi-Cal Capitation Revenue	18,424,478	16,294,596	2,129,882	13.1%
18,473,736	17,706,976	766,760	4.3%	Medicare Capitation Revenue Part C	122,910,950	107,301,134	15,609,816	14.5%
8,208,817	5,188,853	3,019,964	58.2%	Medicare Capitation Revenue Part D	33,458,276	31,294,571	2,163,705	6.9%
-	-	-	0.0%	Other Income	-	-	-	0.0%
29,612,806	**25,598,552**	**4,014,254**	**15.7%**	**Total Operating Revenue**	**174,793,704**	**154,890,301**	**19,903,403**	**12.8%**
				Medical Expenses				
11,782,896	11,256,059	(526,837)	(4.7%)	Provider Capitation	77,318,536	68,386,403	(8,932,133)	(13.1%)
5,969,183	4,087,257	(1,881,926)	(46.0%)	Facilities Claims	28,257,761	24,176,304	(4,081,457)	(16.9%)
1,027,340	961,486	(65,854)	(6.8%)	Ancillary	5,894,089	5,644,489	(249,600)	(4.4%)
1,419,872	1,544,447	124,575	8.1%	MLTSS	8,628,646	9,260,805	632,159	6.8%
7,257,499	5,999,366	(1,258,133)	(21.0%)	Prescription Drugs	38,097,478	35,373,355	(2,724,123)	(7.7%)
1,111,795	1,225,457	113,662	9.3%	Medical Management	6,522,581	7,173,025	650,444	9.1%
115,500	223,556	108,056	48.3%	Other Medical Expenses	827,744	1,302,680	474,936	36.5%
28,684,085	**25,297,628**	**(3,386,457)**	**(13.4%)**	**Total Medical Expenses**	**165,546,835**	**151,317,061**	**(14,229,774)**	**(9.4%)**
928,721	**300,924**	**627,797**	**208.6%**	**Gross Margin**	**9,246,870**	**3,573,240**	**5,673,630**	**158.8%**
				Administrative Expenses				
669,523	810,161	140,638	17.4%	Salaries, Wages & Employee Benefits	4,199,865	4,748,560	548,695	11.6%
(14,172)	40,083	54,255	135.4%	Professional Fees	100,266	240,498	140,232	58.3%
76,006	103,412	27,406	26.5%	Purchased Services	528,945	620,472	91,527	14.8%
65,613	106,517	40,904	38.4%	Printing and Postage	492,875	639,102	146,227	22.9%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
36,161	15,861	(20,300)	(128.0%)	Other Operating Expenses	256,098	97,154	(158,944)	(163.6%)
700,977	553,492	(147,485)	(26.6%)	Indirect Cost Allocation	3,594,928	3,320,952	(273,976)	(8.2%)
1,534,108	**1,629,526**	**95,418**	**5.9%**	**Total Administrative Expenses**	**9,172,977**	**9,666,738**	**493,761**	**5.1%**
(605,387)	**(1,328,602)**	**723,215**	**54.4%**	**Change in Net Assets**	**73,893**	**(6,093,498)**	**6,167,391**	**101.2%**
96.9%	***98.8%***	***2.0%***	***2.0%***	***Medical Loss Ratio***	***94.7%***	***97.7%***	***3.0%***	***3.1%***
5.2%	***6.4%***	***1.2%***	***18.6%***	***Admin Loss Ratio***	***5.2%***	***6.2%***	***1.0%***	***15.9%***

ONECARE CONNECT INCOME STATEMENT– DECEMBER MONTH:

REVENUES of $29.6 million are favorable to budget $4.0 million driven by:

- Favorable volume related variance of $1.7 million
- Favorable price related variance of $2.3 million

MEDICALEXPENSES of $28.7 million are unfavorable to budget $3.4 million driven by:

- Unfavorable volume related variance of $1.7 million
- Unfavorable price related variance of $1.7 million
  - Facilities Claims expense unfavorable variance of $1.6 million
  - Prescription Drugs expense unfavorable variance of $0.9 million
  - Offset by MLTSS expense favorable variance of $0.2 million
  - Provider Capitation expense favorable variance of $0.2 million

ADMINISTRATIVE EXPENSES of $1.5 million are favorable to budget $0.1 million

CHANGE IN NET ASSETS is ($0.6) million, favorable to budget $0.7 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,609	**1,378**	**231**	**16.8%**	**Member Months**	**9,503**	**8,268**	**1,235**	**14.9%**
				Revenues				
1,418,255	1,141,401	276,854	24.3%	Medicare Part C revenue	8,358,173	6,888,778	1,469,395	21.3%
787,375	536,986	250,389	46.6%	Medicare Part D revenue	3,945,182	3,222,666	722,516	22.4%
2,205,630	**1,678,387**	**527,243**	**31.4%**	**Total Operating Revenue**	**12,303,356**	**10,111,444**	**2,191,912**	**21.7%**
				Medical Expenses				
592,860	441,975	(150,885)	(34.1%)	Provider Capitation	3,353,727	2,667,441	(686,286)	(25.7%)
591,595	455,391	(136,204)	(29.9%)	Inpatient	2,837,754	2,729,188	(108,566)	(4.0%)
96,761	43,581	(53,180)	(122.0%)	Ancillary	470,148	258,130	(212,018)	(82.1%)
4,309	25,895	21,586	83.4%	Skilled Nursing Facilities	196,297	153,698	(42,599)	(27.7%)
670,998	498,160	(172,838)	(34.7%)	Prescription Drugs	3,614,065	2,927,539	(686,526)	(23.5%)
35,902	44,341	8,439	19.0%	Medical Management	204,060	261,560	57,500	22.0%
1,992,425	**1,509,343**	**(483,082)**	**(32.0%)**	**Total Medical Expenses**	**10,676,051**	**8,997,556**	**(1,678,495)**	**(18.7%)**
213,205	**169,044**	**44,161**	**26.1%**	**Gross Margin**	**1,627,305**	**1,113,888**	**513,417**	**46.1%**
				Administrative Expenses				
71,536	68,706	(2,830)	(4.1%)	Salaries, wages & employee benefits	504,995	404,925	(100,070)	(24.7%)
6,012	16,000	9,988	62.4%	Professional fees	86,012	96,000	9,988	10.4%
9,184	9,750	566	5.8%	Purchased services	49,224	58,500	9,276	15.9%
7,688	8,084	396	4.9%	Printing and postage	34,520	48,504	13,984	28.8%
-	537	537	100.0%	Other operating expenses	205	3,222	3,017	93.6%
56,377	35,185	(21,192)	(60.2%)	Indirect cost allocation, occupancy expense	253,039	211,110	(41,929)	(19.9%)
150,797	**138,262**	**(12,535)**	**(9.1%)**	**Total Administrative Expenses**	**927,995**	**822,261**	**(105,734)**	**(12.9%)**
62,408	**30,782**	**31,626**	**102.7%**	**Change in Net Assets**	**699,310**	**291,627**	**407,683**	**139.8%**
90.3%	***89.9%***	***(0.4%)***	***(0.5%)***	***Medical Loss Ratio***	***86.8%***	***89.0%***	***2.2%***	***2.5%***
6.8%	***8.2%***	***1.4%***	***17.0%***	***Admin Loss Ratio***	***7.5%***	***8.1%***	***0.6%***	***7.2%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
394	**430**	**(36)**	**(8.4%)**	**Member Months**	**2,317**	**2,484**	**(167)**	**-6.7%**
				Revenues				
2,513,276	2,707,344	(194,068)	(7.2%)	Medi-Cal Capitation Revenue	14,581,315	15,637,862	(1,056,547)	(6.8%)
594,222	629,452	(35,230)	(5.6%)	Medicare Part C Revenue	3,828,170	3,660,116	168,054	4.6%
166,471	153,033	13,438	8.8%	Medicare Part D Revenue	1,052,558	884,193	168,365	19.0%
3,273,969	**3,489,829**	**(215,860)**	**(6.2%)**	**Total Operating Revenue**	**19,462,043**	**20,182,171**	**(720,128)**	**(3.6%)**
				Medical Expenses				
901,260	998,763	97,503	9.8%	Medical Management	5,160,943	5,752,019	591,076	10.3%
334,269	846,021	511,752	60.5%	Facilities Claims	3,524,655	4,738,396	1,213,741	25.6%
774,923	704,460	(70,463)	(10.0%)	Professional Claims	3,732,550	3,971,259	238,709	6.0%
124,084	266,638	142,554	53.5%	Patient Transportation	680,457	1,506,486	826,029	54.8%
306,459	287,854	(18,605)	(6.5%)	Prescription Drugs	1,731,650	1,634,567	(97,083)	(5.9%)
340,047	68,678	(271,369)	(395.1%)	MLTSS	330,370	374,168	43,798	11.7%
4,925	19,343	14,418	74.5%	Other Expenses	113,322	110,532	(2,790)	(2.5%)
2,785,966	**3,191,757**	**405,791**	**12.7%**	**Total Medical Expenses**	**15,273,947**	**18,087,427**	**2,813,480**	**15.6%**
488,003	**298,072**	**189,931**	**63.7%**	**Gross Margin**	**4,188,096**	**2,094,744**	**2,093,352**	**99.9%**
				Administrative Expenses				
76,348	132,920	56,572	42.6%	Salaries, wages & employee benefits	686,164	742,126	55,962	7.5%
123	166	43	25.7%	Professional fees	780	996	216	21.7%
26,983	39,651	12,668	31.9%	Purchased services	99,719	150,406	50,687	33.7%
7,702	17,325	9,623	55.5%	Printing and postage	64,607	81,450	16,843	20.7%
2,020	2,070	50	2.4%	Depreciation & amortization	12,181	12,420	239	1.9%
2,300	4,537	2,237	49.3%	Other operating expenses	17,508	23,342	5,834	25.0%
27,044	4,577	(22,467)	(490.9%)	Indirect Cost Allocation, Occupancy Expense	44,726	26,861	(17,865)	(66.5%)
142,520	**201,246**	**58,726**	**29.2%**	**Total Administrative Expenses**	**925,685**	**1,037,601**	**111,916**	**10.8%**
				Operating Tax				
5,936	-	5,936	0.0%	Tax Revenue	34,384	-	34,384	0.0%
5,936	-	(5,936)	0.0%	Premium Tax Expense	34,384	-	(34,384)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
345,483	**96,826**	**248,657**	**256.8%**	**Change in Net Assets**	**3,262,411**	**1,057,143**	**2,205,268**	**208.6%**
85.1%	***91.5%***	***6.4%***	***7.0%***	***Medical Loss Ratio***	***78.5%***	***89.6%***	***11.1%***	***12.4%***
4.4%	***5.8%***	***1.4%***	***24.5%***	***Admin Loss Ratio***	***4.8%***	***5.1%***	***0.4%***	***7.5%***

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

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
37,165	55,000	17,835	32.4%	Purchase services	238,535	330,000	91,465	27.7%
170,956	177,250	6,294	3.6%	Depreciation & amortization	1,026,191	1,063,500	37,309	3.5%
18,423	18,500	77	0.4%	Insurance expense	110,536	111,000	464	0.4%
119,920	114,916	(5,004)	(4.4%)	Repair and maintenance	624,923	689,500	64,577	9.4%
36,566	41,250	4,684	11.4%	Other Operating Expense	324,063	247,500	(76,563)	(30.9%)
(383,031)	(406,916)	(23,885)	(5.9%)	Indirect allocation, Occupancy	(2,324,249)	(2,441,500)	(117,251)	(4.8%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

OTHER INCOME STATEMENTS – DECEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $62.4 thousand, favorable to budget $31.6 thousand

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.3 million, favorable to budget $0.2 million

CalOptima
Balance Sheet
December 31, 2020

ASSETS		
Current Assets		
Operating Cash		$410,226,522
Investments		771,982,646
Capitation receivable		354,539,870
Receivables - Other		40,259,446
Prepaid expenses		6,889,439
Total Current Assets		**1,583,897,923**
Capital Assets		
Furniture & Equipment	40,923,636	
Building/Leasehold Improvements	11,011,151	
505 City Parkway West	51,628,218	
	103,563,004	
Less: accumulated depreciation	(56,383,869)	
Capital assets, net		47,179,135
Other Assets		
Restricted Deposit & Other		300,000
Homeless Health Reserve		57,198,913
Board-designated assets:		
Cash and Cash Equivalents		2,174,904
Long-term Investments		586,404,630
Total Board-designated Assets		588,579,534
Total Other Assets		646,078,447
TOTAL ASSETS		**2,277,155,504**
Deferred Outflows		
Contributions		1,047,297
Difference in Experience		4,280,308
Excess Earning		-
Changes in Assumptions		5,060,465
OPEB 75 Changes in Assumptions		703,000
Pension Contributions		570,000
TOTAL ASSETS & DEFERRED OUTFLOWS		**2,288,816,574**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$45,070,735
Medical Claims liability	975,548,407
Accrued Payroll Liabilities	14,952,089
Deferred Revenue	19,607,055
Deferred Lease Obligations	144,282
Capitation and Withholds	138,487,234
Total Current Liabilities	**1,193,809,802**
Other (than pensions) post employment benefits liability	26,104,933
Net Pension Liabilities	27,210,891
Bldg 505 Development Rights	-
TOTAL LIABILITIES	**1,247,125,626**
Deferred Inflows	
Excess Earnings	506,547
OPEB 75 Difference in Experience	804,000
Change in Assumptions	3,728,725
OPEB Changes in Assumptions	1,638,000
Net Position	
TNE	102,638,683
Funds in Excess of TNE	932,374,993
TOTAL NET POSITION	1,035,013,676
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**2,288,816,574**

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

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,998,073				
	Tier 1 - MetLife	159,847,291				
	Tier 1 - Wells Capital	160,108,714				
Board-designated Reserve		480,954,078	322,707,512	504,998,739	158,246,566	(24,044,661)
TNE Requirement	Tier 2 - MetLife	107,625,455	102,638,683	102,638,683	4,986,773	4,986,773
	Consolidated:	**588,579,534**	**425,346,195**	**607,637,422**	**163,233,338**	**(19,057,888)**
	Current reserve level	*1.94*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
December 31, 2020

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	8,289,873	9,882,379
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	466,379	2,797,643
Changes in assets and liabilities:		
Prepaid expenses and other	(1,235,595)	(190,231)
Catastrophic reserves		
Capitation receivable	(9,806,048)	51,570,709
Medical claims liability	16,613,964	58,396,387
Deferred revenue	(1,592,929)	(3,816,641)
Payable to health networks	(23,273,178)	(4,493,793)
Accounts payable	12,570,479	(29,585,711)
Accrued payroll	(410,963)	1,699,162
Other accrued liabilities	(2,798)	(16,576)
Net cash provided by/(used in) operating activities	1,619,184	86,243,329
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(17,337,897)	(47,796,333)
Change in Property and Equipment	(288,706)	(3,322,208)
Change in Board designated reserves	(761,703)	(3,695,640)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(18,388,307)	(54,814,181)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(16,769,123)	31,429,148
CASH AND CASH EQUIVALENTS, beginning of period	$426,995,645	378,797,374
CASH AND CASH EQUIVALENTS, end of period	**410,226,522**	**410,226,522**

BALANCE SHEET – DECEMBER MONTH:

ASSETS of $2.3 billion increased $12.2 million from November or 0.5%

- Investments increased $17.3 million due to the timing of cash receipts and month-end requirements for operating cash
- Receivables - Other increased $5.0 million due to increase in estimated receivables relating to pharmacy experience
- Capitation Receivables increased $4.8 million due to the timing of cash receipts and disbursements
- Operating Cash decreased $16.8 million due to the timing of cash receipts and disbursements

LIABILITIES of $1.2 billion increased $3.9 million from November or 0.3%

- Claims Liabilities increased $16.6 million due to timing of claim payment and changes in IBNR
- Accounts Payable increased $12.6 million due to payment of Managed Care Organization (MCO) tax
- Capitation and Withhold decreased $23.3 million due to timing of capitation payments

NET ASSETS of $1.0 billion, increased $8.3 million from November or 0.8%

Summary of Homeless Health Initiatives and Allocated Funds
As of December 31, 2020

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,231,087		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000		
Funds Allocation Total		**$**	**42,801,087**
Program Commitment Balance, available for new initiatives*		**$**	**57,198,913**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

Budget Allocation Changes
Reporting Changes for December 2020

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Maintenance HW/SW – Corporate Application SW - LexisNexis	Maintenance HW/SW – HR Corporate Application SW - SilkRoad	$12,000	To repurpose funds from LexisNexis renewal to fund shortages in SilkRoad renewal and additional licenses	2021
October	Medi-Cal	Maintenance HW/SW - UPS Maintenance	Maintenance HW/SW - Desktop - Adobe Acrobat	$35,000	To repurpose funds from UPS Maintenance to fund shortages in Desktop - Adobe Acrobat	2021
October	Medi-Cal	Maintenance HW/SW - Microsoft True-Up	Maintenance HW/SW - Desktop - Microsoft Enterprise License Agreement	$91,000	To repurpose funds from Microsoft License True-Up to fund shortages in the new 3-year Microsoft Enterprise License Agreement	2021
November	Medi-Cal	Business Integration - Temporary Help	Process Excellence - Temporary Help	$43,000	To reallocate funds from Business Integration - Temporary Help to Process Excellence - Temporary Help for an Analyst.	2021

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

Board of Directors Meeting
February 4, 2021

Monthly Compliance Report

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

A. Updates on Regulatory Audits

1. OneCare

- 2021 PACE and Medicare Parts C and D Program Audits (*applicable to OneCare, OneCare Connect and PACE*):

  On December 23, 2020, the Centers for Medicare & Medicaid Services (CMS) outlined how it will proceed with PACE and Medicare Parts C and D program audit activities in light of the ongoing public health emergency. CMS expects to proceed with program audits in calendar year 2021, and will send audit engagement letters to organizations from mid-March through September 2021 on a rolling basis. CMS will provide the same flexibilities in 2021 that were granted to audited organizations in 2020. The flexibilities include additional time to provide requested documentation, respond to questions, respond to the draft audit report, implement corrective actions, and demonstrate the correction of findings. CalOptima's Office of Compliance continues to prepare impacted stakeholders for these anticipated audits.

- 2021 Medicare Parts C and D Data Validation Audit (*applicable to OneCare and OneCare Connect*):

  On an annual basis, CMS requires all plan sponsors to engage an independent auditor to validate all Medicare Parts C and D data reported for the prior calendar year. CalOptima has requested the required Parts C and D reporting data from all impacted business areas to ensure the accuracy of the data prior to submission in February 2021. The validation audit is expected to take place starting in March and conclude in June 2021. The audit includes a webinar validation and source documentation review for the following Medicare Parts C and D measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations

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- Medicare Therapy Management (MTM) Program
- Special Needs Plan (SNP) Care Management
- Improving Drug Utilization Review (IDUR) Controls

CalOptima departments are working to review their reported data for submission by the CMS deadlines of 2/1/21 and 2/22/21.

- 2021 Timeliness Monitoring Project (TMP):

  On September 18, 2020, CMS announced it will conduct the industry wide Timeliness Monitoring Project (TMP) starting in January 2021. CMS will collect data for organization determinations, and appeals and grievances (ODAG) to assess timeliness in processing Medicare Advantage (Part C) reconsiderations, as well as compliance with forwarding cases to the independent review entity (IRE). Findings may result in compliance actions, if necessary, and may have implications for the Star Ratings. On January 11, 2021, CMS formally engaged CalOptima's OneCare program for the TMP. Requested universe data are due to CMS by January 26, 2021.

  On a separate but related note, on December 21, 2020, CalOptima received the results of the 2020 TMP, which indicated zero (0) untimely cases and errors for both the Part C and Part D measures. Given that there are no findings, CMS has closed the 2020 TMP for CalOptima.

- Medicare Part D Prescription Drug Event (PDE) Validation (PEPV) Audit (*applicable to OneCare and OneCare Connect*):

  By way of background, on January 10, 2020, CMS informed CalOptima that both its OneCare and OneCare Connect programs were selected to participate in the CY 2018 Medicare PEPV audit. Through the PEPV audit, CMS validates the accuracy of PDE data submitted by Medicare Part D sponsors for CY 2018 payments. On February 20, 2020, CalOptima completed its PDE data submission to CMS.

  On December 23, 2020, CMS issued the final findings report for the CY 2018 Medicare PEPV audit. For both programs, CMS successfully validated all the PDE records sampled with no findings.

- CY 2021 Monitoring of Posted Comprehensive Formularies Analysis (PvA33):

  By way of background, on November 4, 2020, CMS announced its review to compare the formularies posted on plan websites for CY 2021 to their approved formularies that will be effective January 1, 2021. CMS selected a random sample of Part D plans for inclusion, excluding PACE organizations, in the CY 2021 Monitoring of PvA. On November 11, 2020, CMS separately notified CalOptima that its OneCare contract has been selected for the CY 2021 Monitoring of PvA.

  On December 14, 2020, CMS notified CalOptima that there were no potential discrepancies or findings identified during the review. No further action is required.

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

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2. OneCare Connect

- CY 2018 Medicare Part C Improper Payment Measurement (IPM) Activities (formerly known as National Risk Adjustment Data Validation (NAT18 RADV):

  On January 13, 2020, CMS informed CalOptima that its OneCare Connect program was selected to participate in the CY 2018 Medicare Part C Improper Payment Measurement (IPM), formerly known as the National Risk Adjustment Data Validation (RADV) audit. CMS conducts medical record reviews to validate the accuracy of the CY 2018 Medicare Part C risk adjustment data. The results of this review will be used to calculate a program-wide improper payment rate for Medicare Part C.

  On December 21, 2020, CMS issued the final report for the CY 2018 Medicare Part C IPM audit. CMS confirmed all selected hierarchical condition categories (HCCs) with medical records submitted by CalOptima. Given that no findings were identified, CMS requires no further action.

- Performance Measure Validation (PMV) for Medicare-Medicaid Plans (MMPs):

  By way of background, CMS requires MMPs to report various monitoring and performance measures, as outlined in the MMP Core Reporting Requirements and MMP State-Specific Reporting Requirements. In order to ensure MMPs' reported data are reliable, valid, complete, and comparable, CMS conducts ongoing PMV of select core and state-specific measures.

  On July 8, 2020, CMS' contractor, HSAG/NORC, notified CalOptima of its selection for validation of two (2) performance measures for its OneCare Connect program:

  - MMP Core 2.1: Members with an assessment completed within 90 days of enrollment
  - MMP Core 3.2: Members with a care plan completed within 90 days of enrollment

  On September 15, 2020, CMS conducted the validation audit by webinar. On December 21, 2020, HSAG/NORC issued preliminary results, which indicated that measure data were compliant with CMS' specifications and the data, as reported, were valid for both performance measures. The final report is expected to be released on January 15, 2021.

3. PACE

- 2019 CMS Financial Audit:

  On August 13, 2020, CMS notified CalOptima PACE that it has been selected for the 2019 CMS Financial Audit. By way of background, at least one-third of Medicare Advantage Organizations (MAOs) are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CalOptima was notified that the Certified Public Accountant (CPA) firm, Myers & Stauffer, will be leading this audit. Myers & Stauffer will audit and inspect any books and records from

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CalOptima that pertain to 1) the ability of the organization to bear the risk of potential financial losses, or 2) services performed or determinations of amounts payable under the contract.

On December 4, 2020, Myers & Stauffer notified CalOptima of the selection of the prescription drug event (PDE) samples and associated documentation request. On January 7, 2021, CalOptima submitted the full set of PDE samples to Myers & Stauffer.

4. Medi-Cal

➢ 2020 DHCS Medical Audit:

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

On August 11, 2020, the DHCS provided CalOptima with a final audit report and a formal request for a corrective action plan (CAP). The report identified seven (7) Medi-Cal findings in the audit areas of Access and Availability of Care and Member's Rights. CalOptima did not receive any findings for State Supported Services or the Cal MediConnect program. CalOptima submitted a timely CAP to the DHCS by the deadline of September 11, 2020.

As part of the CAP process, CalOptima provided monthly updates to the DHCS in October, November, and December 2020. The DHCS has confirmed that they are currently reviewing the December update and additional monthly updates are no longer required. The DHCS will continue to review the CAP and provide CalOptima with any feedback and support, as necessary.

B. Regulatory Notices of Non-Compliance

- By way of background, on July 21, 2020, CMS released the results of the 2020 Accuracy & Accessibility Study. This study was conducted from February through May 2020. On November 30, 2020, CMS issued a Warning Letter to CalOptima for failure to meet call center standards for prospective beneficiary customer service phone lines related to the 2020 TTY functionality measure for OneCare Connect. CMS issued a Warning Letter because it had previously issued a Notice of Non-Compliance to CalOptima for failure to comply with similar requirements for 2019. CalOptima has fully remediated the deficiency, and no further action is required by CMS.

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

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

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C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring Dashboard: Medi-Cal Grievance & Appeals Resolution Services (GARS) [a\]

- As part of the monitoring process, CalOptima's Audit & Oversight department, in collaboration with business areas, maintains a dashboard to monitor key performance metrics for internal and external operations on a monthly basis. Dashboard results are presented to CalOptima's Audit & Oversight Committee and Compliance Committee for oversight. Below are the dashboard results for the months of August 2020 – October 2020 for Medi-Cal GARS. CalOptima's GARS department continues to not meet resolution timeliness requirements for five (5) consecutive months for Medi-Cal expedited appeals and for two (2) consecutive months for Medi-Cal standard appeals.

Month	Compliance Goal	Expedited Appeals Resolved within ≤ 72 Hours of Receipt
August 2020	98%	88%
September 2020	98%	88%
October 2020	98%	75%

Month	Compliance Goal	Standard Appeals Resolved within ≤ 30 Calendar Days of Receipt
August 2020	98%	98%
September 2020	98%	90%
October 2020	98%	67%

- CalOptima's Audit & Oversight (A&O) department escalated the CAP that was previously issued to an immediate corrective action plan (ICAP) as issues with non-timely processing of Medi-Cal appeals have extended to both expedited and standard appeals and appear to be systemic, may have the potential to cause member harm, and have been ongoing for at least three (3) months. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard and expedited appeals.

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

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2. Internal Monitoring: Medi-Cal[a\]

- Medi-Cal GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved within ≤ 30 Calendar Days of Receipt
August 2020	100%	100%	100%	100%	100%
September 2020	100%	100%	100%	75%	66.67%
October 2020	100%	100%	95%	0%	0%

- Based on a focused review of twelve (12) Medi-Cal standard appeals for September 2020, the lower compliance score of 75% for member notice content was due to three (3) files exceeding the sixth (6th) grade reading level.

- Based on a focused review of twelve (12) Medi-Cal standard appeals for September 2020, the lower compliance score of 66.67% for resolution of appeals was due to four (4) files not meeting the timeframe for processing a standard appeal.

- Based on a focused review of twenty (20) Medi-Cal standard appeals for October 2020, the lower compliance score of 95% for language preference was due to one (1) resolution letter not being in the member's preferred language.

- Based on a focused review of twenty (20) Medi-Cal standard appeals for October 2020, all twenty (20) files exceeded the sixth (6th) grade reading level leading to the low compliance score of 0% for member notice content.

- Based on a focused review of twenty (20) Medi-Cal standard appeals for October 2020, all twenty (20) files did not meet the timeframe for processing a standard appeal resulting in a low compliance score of 0% for resolution timeliness.

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

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

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- Medi-Cal GARS: Expedited Appeals

Month(s)	Classification Score	Expedited Appeals Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Resolution of Expedited Appeals Resolved within 72 Hours of Receipt
August 2020	100%	100%	100%	100%	90%
September 2020	100%	100%	100%	37.5%	87.5%
October 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - Based on a focused review of ten (10) Medi-Cal expedited appeals for August 2020, the lower compliance score of 90% for resolution timeliness was due to one (1) file not being resolved within the required timeframe.

  - Based on a focused review of eight (8) Medi-Cal expedited appeals for September 2020, the lower compliance score of 37.5% for member notice content was due to five (5) files exceeding the sixth(6^{th}) grade reading level.

  - Based on a focused review of eight (8) Medi-Cal expedited appeals for September 2020, the lower compliance score of 87.5% for expedited appeals resolved within 72 hours of receipt was due to one (1) file not meeting the timeframe for processing an expedited appeal.

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

- Medi-Cal GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievance Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Standard Resolution of Grievances Resolved within ≤ 30 Calendar Days of Receipt
August 2020	100%	100%	100%	77.77%	100%
September 2020	100%	100%	100%	83.33%	83.33%
October 2020	100%	100%	94.44%	77.77%	100%

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

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- Based on a focused review of eighteen (18) Medi-Cal standard grievances for September 2020, the lower compliance score of 83.33% for member notice content was due to three (3) files exceeding the sixth (6th) grade reading level.

- Based on a focused review of eighteen (18) Medi-Cal standard grievances for September 2020, the lower compliance score of 83.33% for resolution of standard grievances resolved within 30 calendar days of receipt was due to three (3) files not meeting the timeframe for processing a standard grievance.

- Based on a focused review of eighteen (18) Medi-Cal standard grievances for October 2020, the lower compliance score of 77.77% for member notice content was due to four (4) files exceeding the sixth (6th) grade reading level.

- Based on a focused review of eighteen (18) Medi-Cal standard grievances for October 2020, the lower compliance score of 94.44% for language preference was due to one (1) resolution letter not being in the member's preferred language.

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

- Medi-Cal GARS: Expedited Grievances

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
August 2020	100%	100%	90.9%	72.7%	100%
September 2020	100%	100%	100%	100%	100%
October 2020	100%	100%	100%	75%	100%

- Based on a focused review of four (4) Medi-Cal expedited grievances for October 2020, the lower compliance score of 75% for member notice content was due to one (1) file exceeding the sixth (6th) grade reading level.

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

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

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- Medi-Cal Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
August 2020	90%	70%	100%	70%	100%	100%	90%
September 2020	100%	70%	100%	80%	100%	100%	100%
October 2020	100%	100%	100%	100%	100%	100%	100%

  - Based on a focused review of ten (10) Medi-Cal prior authorizations for September 2020, the lower compliance score of 70% was due to untimely resolution of three (3) prior authorizations.

  - Based on a focused review of ten (10) Medi-Cal prior authorizations for September 2020, the lower compliance score of 80% for clinical decision making review was due to not following the appropriate ordering for clinical decision making for two (2) standard prior authorizations.

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

- Medi-Cal Utilization Management: Urgent Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Members Preferred Language	Accuracy of Member Notice Content
August 2020	100%	100%	100%	100%	100%	100%	80%
September 2020	100%	80%	100%	100%	100%	100%	100%
October 2020	100%	80%	100%	90%	100%	100%	100%

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

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- Based on a focused review of ten (10) Medi-Cal urgent prior authorization for September 2020, the lower compliance score of 80% was due to untimely resolution of two (2) urgent prior authorizations.

- Based on a focused review of ten (10) Medi-Cal urgent prior authorization for October 2020, the lower compliance score of 80% was due to untimely resolution of two (2) urgent prior authorizations.

- Based on a focused review of ten (10) Medi-Cal urgent prior authorizations for October 2020, the lower compliance score of 90% for clinical decision making review was due to not following the appropriate ordering for clinical decision making for one (1) urgent prior authorization.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of urgent Medi-Cal prior authorizations. The A&O department continues to work with the Utilization Management department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of urgent prior authorizations.

3. Internal Monitoring: OneCare [a\]

- OneCare GARS: Standard Appeals

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

- Based on a focused review of four (4) OneCare standard appeals for October 2020, the lower compliance score of 0% for member notice content was due to all four (4) files exceeding the sixth (6^{th}) grade reading level.

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

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

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- OneCare GARS: Payment Reconsideration Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved within ≤ 30 Calendar Days of Receipt
August 2020	100%	100%	100%	100%	100%
September 2020	100%	100%	100%	100%	100%
October 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - There are no significant updates to provide for the file review of OneCare payment reconsideration appeals for the months of August through October 2020.

- OneCare GARS: Standard Grievances

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved within ≤ 30 Calendar Days of Receipt
August 2020	100%	100%	100%	57.14%	100%
September 2020	100%	100%	100%	0%	100%
October 2020	100%	100%	100%	50%	100%

  - Based on a focused review of three (3) OneCare standard grievances for September 2020, the lower compliance score of 0% for member notice content was due to all three (3) files exceeding the sixth (6^{th}) grade reading level.

  - Based on a focused review of two (2) OneCare standard grievances for October 2020, the lower compliance score of 50% for member notice content was due to one (1) file exceeding the sixth (6^{th}) grade reading level.

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

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

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- OneCare Utilization Management: Standard Pre-Service Organization Determinations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
August 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
September 2020	100%	100%	100%	100%	100%	100%	100%
October 2020	100%	100%	100%	100%	100%	100%	100%

➢ There are no significant updates to provide for the file review of OneCare standard pre-service organization determinations for the months of August through October 2020.

4. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved within ≤ 30 Calendar Days of Receipt
August 2020	100%	100%	100%	70%	100%
September 2020	100%	100%	100%	18.18%	100%
October 2020	100%	100%	100%	25%	66.67%

➢ Based on a focused review of eleven (11) OneCare Connect standard appeals for September 2020, the lower compliance score of 18.18% for member notice content was due to nine (9) files failing for the following reasons:
  – Eight (8) files failed due to the resolution letter not being issued at the sixth (6^{th}) grade reading level.
  – One (1) file failed due to the acknowledgement letter not including the contact information for CalOptima's Resolution Specialist.

➢ Based on a focused review of twelve (12) OneCare Connect standard appeals for October 2020, the lower compliance score of 25% for member notice content was due to nine (9) files exceeding the 6^{th} grade reading level.

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

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- Based on a focused review of twelve (12) OneCare Connect standard appeals for October 2020, the lower compliance score of 66.67% was due to untimely resolution of four (4) standard appeals.

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

- OneCare Connect GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievance Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievance Resolved within ≤ 30 Calendar Days of Receipt
August 2020	100%	100%	100%	86.67%	100%
September 2020	100%	100%	100%	60%	100%
October 2020	100%	100%	100%	80%	100%

- Based on a focused review of fifteen (15) OneCare Connect standard grievances for September 2020 file, the lower compliance score of 60% for member notice content was due to six (6) files exceeding the sixth (6th) grade reading level.

- Based on a focused review of fifteen (15) OneCare Connect standard grievances for October 2020, the lower compliance score of 80% for member notice content was due to three (3) files exceeding the sixth (6^{th}) grade reading level.

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

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

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- OneCare Connect Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
August 2020	100%	100%	100%	80%	100%	90%	90%
September 2020	100%	100%	100%	50%	100%	90%	90%
October 2020	100%	100%	90%	90%	100%	90%	100%

  - Based on a focused review of ten (10) OneCare Connect standard prior authorizations for September 2020:
    - The lower compliance score of 50% for clinical decision making review was due to not following the appropriate ordering for clinical decision making for five (5) standard prior authorizations.
    - The lower compliance score of 90% was due to one (1) letter not being in the member's preferred language.
    - The lower compliance score of 90% for accuracy of member notice content was due to one (1) file exceeding the sixth (6^{th}) grade reading level.

  - Based on a focused review of ten (10) OneCare Connect standard prior authorizations for October 2020:
    - The lower compliance score of 90% for provider and member notification timeliness was due to one (1) file not having evidence that the member notification was mailed to the member.
    - The lower compliance score of 90% for clinical decision making review was due to one (1) service approval not including code-specific services.
    - The lower compliance score of 90% for written response in member's preferred language was due to one (1) letter not being in the member's preferred language.

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

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

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- OneCare Connect Utilization Management: Expedited Service Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
August 2020	100%	100%	80%	90%	100%	80%	90%
September 2020	100%	60%	70%	60%	100%	90%	100%
October 2020	100%	70%	90%	80%	100%	100%	100%

- Based on a focused review of ten (10) OneCare Connect expedited service authorizations for September 2020:
  - The compliance score of 60% for resolution timeliness was due to untimely resolution of four (4) expedited service authorizations.
  - The lower compliance score of 70% for provider and member notification timeliness was due to lack of documentation that attempts were made to contact member after medical decision was made for three (3) expedited service authorizations.
  - The lower compliance score of 60% for clinical decision making review was due to not following the appropriate order for clinical decision making for four (4) expedited service authorizations.
  - The compliance score of 90% was due to the letter not being written in the member's preferred language for one (1) approval letter.

- Based on a focused review of ten (10) OneCare Connect expedited service authorizations for October 2020:
  - The compliance score of 70% for resolution timeliness was due to untimely resolutions of three (3) expedited service authorizations.
  - The lower compliance score of 90% for provider and member notification timeliness was due to one (1) unsuccessful fax to the ordering provider.
  - The lower compliance score of 80% for clinical decision making review was due to not following the appropriate order and using the incorrect criteria to make decision in two (2) expedited service authorizations.

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

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

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5. Internal Audits: [a\]

- Medi-Cal Customer Service

  - During the third quarter of 2020, CalOptima's Audit & Oversight (A&O) department conducted a full-scope audit of CalOptima's Medi-Cal Customer Service department to ensure compliance with timeliness standards and proper case documentation for the review period of January 2020 - June 2020.

Measures	Files Reviewed	Compliance Score
Inquiry (Call Logs)		
Misclassified	18	100%
File Review	18	94.44%
Exempt Grievances		
Call Log Requirements	18	100%
Classification of Exempt Grievances	18	100%
Accurate Documentation of Exempt Grievances	18	100%
Complete Resolution of Exempt Grievances	18	100%
Timeliness of Resolution	18	94.44%

  - The A&O department continues to work with the Customer Service department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure timely processing of exempt grievances and inquiries.

- Medicare Customer Service

  - During the third quarter of 2020, CalOptima's Audit & Oversight (A&O) department conducted a full-scope audit of CalOptima's Medicare Customer Service department to ensure compliance with timeliness standards and proper case documentation for the review period of January 2020- June 2020.

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

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- OneCare Internal Audit Results

Measures	Files Reviewed	Compliance Score
Part C Inquiry (Call Logs)		
Misclassified	6	100%
File Review	6	100%
Part D Inquiry (Call Logs)		
Misclassified	6	100%
File Review	6	100%
Oral Grievances		
Misclassified	18	94.44%
File Review	17	100%

- OneCare Connect Internal Audit Results

Measures	Files Reviewed	Compliance Score
Part C MMP Inquiry (Call Logs)		
Misclassified	5	100%
File Review	5	80%
Part D Inquiry (Call Logs)		
Misclassified	6	100%
File Review	6	100%
MMP Oral Grievances		
Misclassified	18	100%
File Review	18	94.44%

- For OneCare, the lower score was attributed to the misclassification of a call as an inquiry instead of a grievance and a missing call recording to validate accuracy of call log notes.

- For OneCare Connect, the lower score was attributed to a grievance exceeding the resolution timeframe.

- The A&O department continues to work with the Customer Service department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to timely and accurate processing of exempt grievances and inquiries.

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

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6. Internal Audits: Medi-Cal and OneCare Connect Credentialing / Recredentialing [a\]

- During the third quarter of 2020, CalOptima's Audit & Oversight (A&O) department conducted a full-scope audit of CalOptima's Quality Improvement department to ensure compliance with timeliness and accuracy requirements for credentialing/recredentialing for the review period of January 2020-June 2020.

- Credentialing File Review

Measures	Files Reviewed	Compliance Score
Credentialing Cycle	N/A	N/A
Monitor Performance of Credentialing	N/A	N/A
Verification of Credentials	7	57.14%
Sanction Information	7	57.14%
Credentialing Application	7	100%
Clinical/Hospital Privileges	7	100%
Medi-Cal Screening & Enrollment	7	100%
Facility Site Review (FSR)	7	100%

  - Based on a focused review of seven (7) credentialing files for CalOptima's Community Network (CCN) from January - June 2020, the lower compliance score of 57.14% for verification of credentials was due to untimely verification of DEA certification, incomplete work history, and inaccurate information on a provider's license.

  - Based on a focused review of seven (7) credentialing files for CCN from January - June 2020, the lower compliance score of 57.14% for sanction information was due to untimely verification of missing documentation and missing report date.

- Recredentialing File Review

Measures	Files Reviewed	Compliance Score
Recredentialing Cycle	8	87.50%
Monitor Performance of Recredentialing	8	100%
Verification of Credentials	8	87.50%
Sanction Information	8	75%
Recredentialing Application	8	100%
Clinical/Hospital Privileges	8	100%
Medi-Cal Screening & Enrollment	8	100%
Facility Site Review (FSR)	8	100%

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

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- Based on a focused review of eight (8) recredentialing files for CCN from January - June 2020, the lower compliance score of 87.50% for recredentialing cycle was due to not meeting timeframes for recredentialing.

- Based on a focused review of seven (7) recredentialing files for CCN from January - June 2020, the lower compliance score of 87.50% for verification of credentials was due to inaccurate information on a provider's license.

- Based on a focused review of eight (8) recredentialing files for CCN from January - June 2020, the lower compliance score of 75% for sanction information was due to missing documentation.

Measures	Files Reviewed	Compliance Score
Behavioral Health (BH) Credentialing		
Credentialing Cycle	N/A	N/A
Monitor Performance of Credentialing	N/A	N/A
Verification of Credentials	8	100%
Sanction Information	8	62.50%
Credentialing Application	8	100%
Clinical/Hospital Privileges	8	100%
Medi-Cal Screening & Enrollment	8	100%
Facility Site Review (FSR)	8	100%

- Based on a focused review of eight (8) BH credentialing files for CCN from January - June 2020, the lower compliance score of 62.50% for sanction information was due to missing documentation.

Measures	Files Reviewed	Compliance Score
Behavioral Health (BH) Recredentialing		
Recredentialing Cycle	8	100%
Monitor Performance of Recredentialing	8	100%
Verification of Credentials	8	100%
Sanction Information	8	75%
Recredentialing Application	8	100%
Clinical/Hospital Privileges	8	100%
Medi-Cal Screening & Enrollment	8	100%
Facility Site Review (FSR)	N/A	N/A

- Based on a focused review of eight (8) BH recredentialing files for CCN from January - June 2020, the lower compliance score of 75% for sanction information was due to missing documentation and missing report date.

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- In addition, CalOptima's Quality Improvement department received a finding due to the lack of a policy and procedure for sub-delegate oversight of the credentialing / recredentialing process.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the internal audit. The A&O department continues to work with the Quality Improvement department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of credentialing and recredentialing files.

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

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

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified	Letter Score for Modified	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
August 2020	77%	100%	100%	91%	99%	96%	96%	96%	96%	99%	67%	89%	100%
September 2020	91%	100%	94%	87%	91%	92%	97%	100%	96%	97%	100%	92%	100%
October 2020	83%	85%	88%	83%	93%	93%	95%	88%	93%	98%	77%	100%	100%

- Based on a focused review of select files, ten (10) health networks contributed to the lower compliance score for timeliness. Of the eighty-one (81) files received from the ten (10) health networks, twenty-one (21) files were deficient. Deficiencies for the lower scores for timeliness included the following:
  - 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 initial notification (24 hours)
  - Failure to meet timeframe for provider written notification (24 hours)

- Based on a focused review of select files, five (5) health networks contributed to the lower compliance score for clinical decision making (CDM). Of the twenty (20) files received from the five (5) health networks, ten (10) files were deficient. Deficiencies for the lower scores for CDM included the following:
  - Failure to have appropriate professional make decision
  - Failure to obtain adequate clinical information
  - Failure to cite criteria for decision

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

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- Based on a focused review of select files, four (4) health networks contributed to the lower compliance rate for letter score. Of the twenty-two (22) files received from the four (4) health networks, eleven (11) files were deficient. Deficiencies for the lower letter scores included the following:
  - 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 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 or modify

- Based on the overall universe of Medi-Cal authorizations for September 2020, CalOptima's health networks received an aggregate compliance score of 99.85% for timely processing of routine authorization requests and a compliance score of 97.88% for timely processing of expedited authorization requests.

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

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2020	100%	100%	100%	91%
September 2020	86%	95%	89%	86%
October 2020	92%	98%	99%	94%

- Based on the overall universe of Medi-Cal claims for September 2020, CalOptima's health networks received an overall compliance score of 96.14% for timely processing of claims.

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

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monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

8. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
August 2020	100%	NTR	89%	100%	90%	97%	100%	97%
September 2020	86%	NTR	90%	100%	90%	100%	100%	100%
October 2020	93%	100%	95%	98%	97%	100%	97%	99%

- Based on a focused review of select files, one (1) health network drove the lower compliance score for timeliness. Out of the ten (10) files received from the health network, two (2) files were deficient. The lower compliance score for timeliness was due to the network's failure to meet the required timeframe for provider notification.

- Based on a focused review of select files, one (1) health network drove the lower compliance score for clinical decision making. Out of the two (2) files received from the health network, one (1) file was deficient. The lower compliance score for clinical decision making was due to the network's failure to cite criteria for the decision.

- Based on a focused review of select files, one (1) health network drove the lower compliance letter score. Out of the two (2) files received from the health network, one (1) file was deficient. The lower letter score was due to the network's failure to describe why the request did not meet criteria in lay language.

- Based on the overall universe of OneCare authorization requests for September 2020, CalOptima's health networks received an overall compliance score of 98.10% for timely processing of standard Part C authorization requests and an overall compliance score of 75% for timely processing of expedited Part C authorization requests.

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

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

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- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2020	88%	88%	86%	86%
September 2020	94%	100%	86%	93%
October 2020	100%	100%	100%	96%

- Based on the overall universe of OneCare claims for September 2020, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
  - 89% for non-contracted clean claims paid or denied within 30 calendar days of receipt
  - 95% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt

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

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

- OneCare Connect Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
August 2020	100%	100%	92%	90%	87%	100%	93%	94%	80%	93%	100%
September 2020	100%	100%	96%	90%	91%	86%	93%	98%	90%	93%	100%
October 2020	88%	93%	92%	97%	94%	85%	87%	96%	83%	92%	99%

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

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- Based on a focused review of select files, seven (7) health networks drove the lower compliance score for timeliness. Of the thirty-two (32) files received from the seven (7) health networks, seven (7) files were deficient. Deficiencies for the lower scores for timeliness included the following:
  - Failure to meet timeframe for decision
  - Failure to meet timeframe for provider initial notification
  - Failure to meet timeframe for provider written notification

- Based on a focused review of select files, six (6) health networks drove the lower compliance score for clinical decision making (CDM). Of the thirty-three (33) files received from the six (6) health networks, twenty-two (22) files were deficient. The lower scores for CDM were due to the health networks' failure to cite criteria for decision.

- Based on a focused review of select files, four (4) health networks drove the lower compliance letter score. Of the twenty-two (22) files received from the four (4) health networks, eleven (11) files were deficient. Deficiencies for the lower letter scores included the following:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide letter with description of services in lay language
  - Failure to include name and contact information for health care professional responsible for the decision to deny or modify

- Based on the overall universe of OneCare Connect authorization requests for September 2020, CalOptima's health networks received an overall compliance score of 99.93% for timely processing of routine authorization requests and 99.14% for timely processing of expedited authorization requests.

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

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

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- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2020	85%	85%	89%	89%
September 2020	80%	90%	100%	97%
October 2020	97%	98%	100%	99%

- Based on the overall universe of OneCare Connect claims for September 2020, CalOptima's health networks received the following overall compliance scores:
  - 97.66% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  - 93.10% for non-contracted and contracted unclean claims paid or denied within 60 calendar days of receipt
  - 99.63% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

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

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

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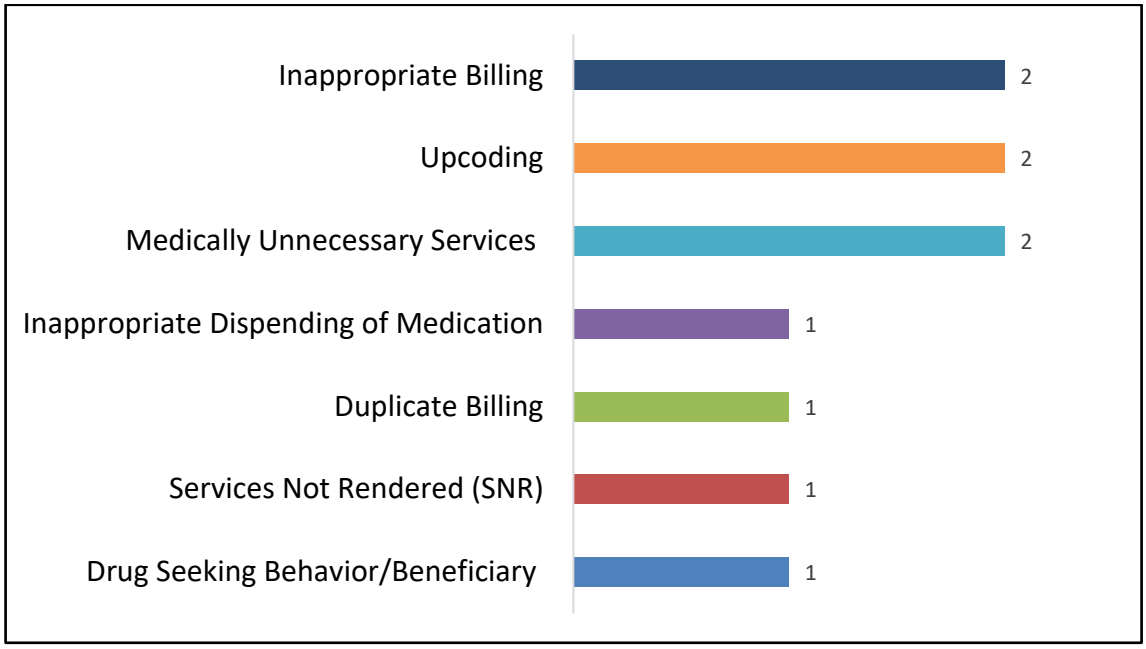
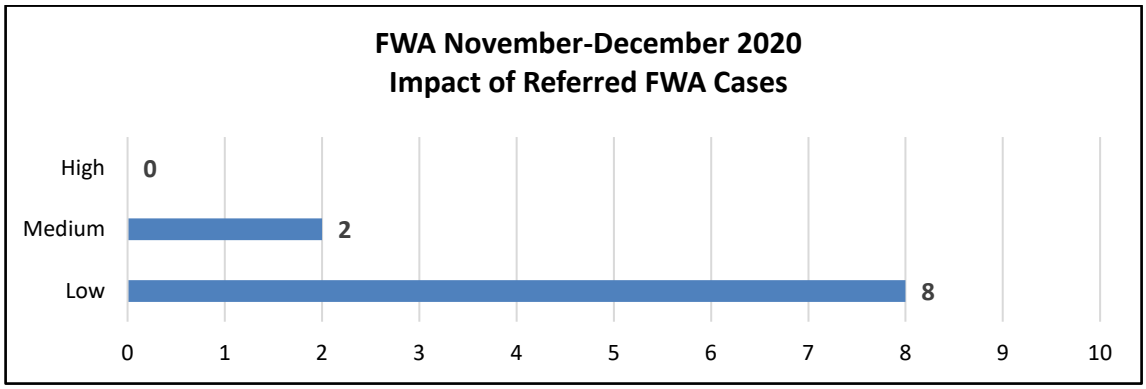
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in November and December 2020)





Total Number of New Cases Referred to DHCS (State)	9
Total Number of Closed Cases Referred to I-MEDIC (CMS)	1
Total Number of Referrals Reported	**10**

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

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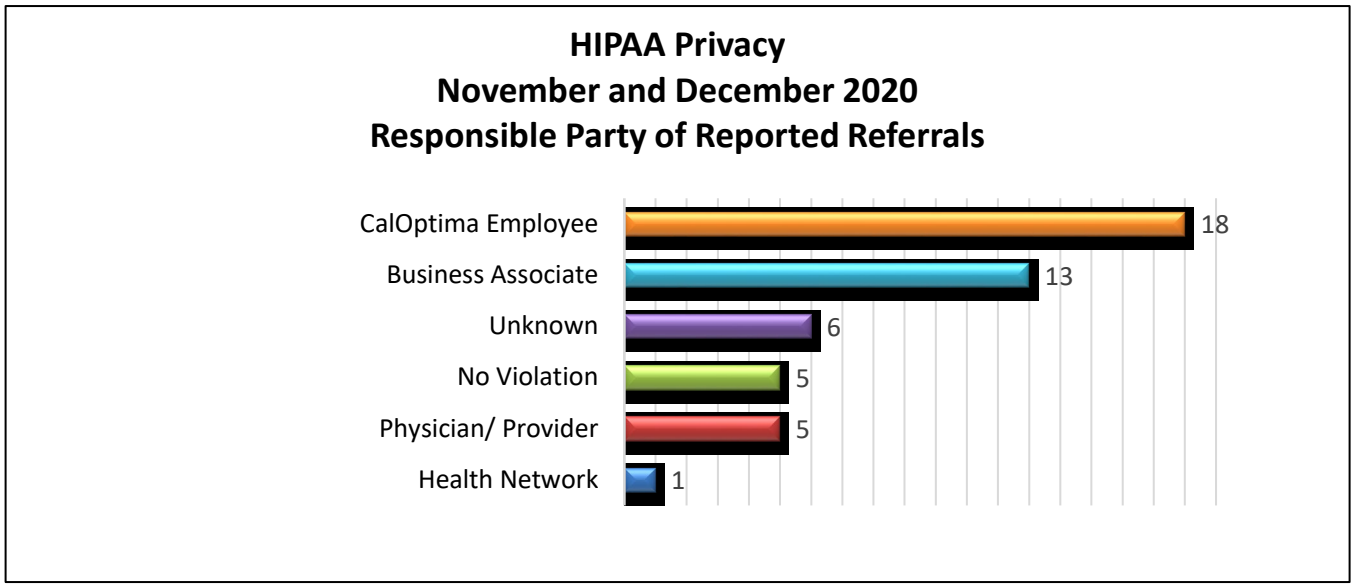
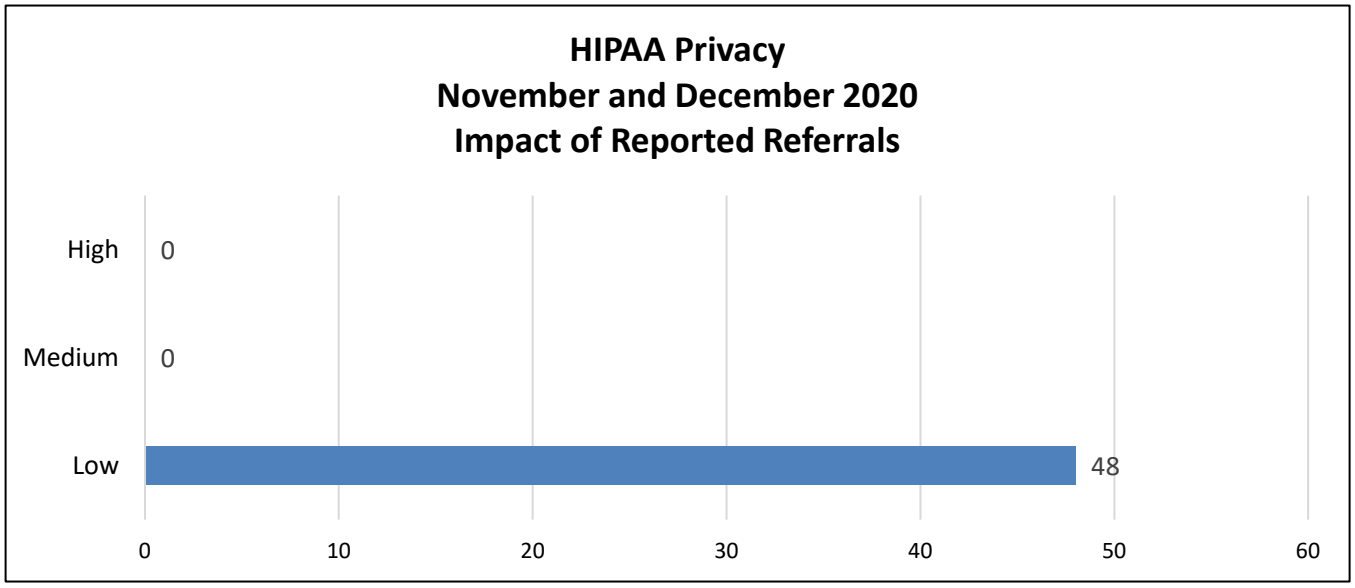
E. Privacy Update: (November and December 2020)





Total Number of Referrals Reported to DHCS (State)	48
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**48**

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

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

January 18, 2020

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: January Board of Directors Report

With the COVID-19 pandemic ongoing and Democrats set to control Congress and the White House, 2021 is likely to be a particularly active year for health-related legislation and executive action. This memorandum discusses the outlook for 2021 and provides an update on legislative developments through January 16, 2020.

FY 2021 Omnibus/COVID Package

Following months of negotiations and a last-minute veto threat, President Trump on December 27 signed into law H.R. 133, the Consolidated Appropriations Act of 2021. The package combines a $1.4 trillion appropriations measure for Fiscal Year (FY) 2021 with a $900 billion COVID-19 relief package, as well as other health-related provisions. The year-end deal provided new money for small-business loans through the Paycheck Protection Program (PPP), expanded unemployment benefits for 10 weeks, a new round of $600 tax rebate checks for families and individuals, and billions of dollars for vaccine distribution, testing, and response activities.

On the health care side, the package included the following provisions:

- Three-month delay of the Medicare sequester payment reductions through March 31, 2021;
- Relief to help offset reimbursement cuts included in the Calendar Year (CY) 2021 physician fee schedule final rule;
- Extended funding for community health centers and other public health programs for three years;
- Eliminated Medicaid Disproportionate Share Hospital (DSH) payment reductions for fiscal year 2021, 2022 and 2023, and adds reductions to fiscal years 2026 and 2027;
- Expanded access to telehealth services in Medicare to allow beneficiaries to receive mental health services via telehealth, including from the beneficiary's home;
- Created new rules to hold patients harmless from surprise medical bills, including from air ambulance providers; and
- Created a new, voluntary Medicare payment designation that allows either a Critical Access Hospital (CAH) or a small, rural hospital with less than 50 beds to convert to a Rural Emergency Hospital (REH).

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The law also included $3 billion for the Provider Relief Fund, along with a requirement that 85 percent of the unobligated money be distributed in consideration of financial losses and operating expense changes. The package also clarified the definition of lost revenue for hospitals to align with the June 2020 guidance on the matter.

While the package did not provide any new direct aid for state and local governments, the Act did extend the deadline for states and localities to use CARES Act funding until December 31, 2021.

117th Congress Overview

The 117th Congress convened on January 3, 2020 with 67 new Members of Congress, including 7 new Senators and 60 new House Members. House and Senate Committees will soon hold organizational meetings to agree on Committee Rules and Leadership spots.

Democrats have a smaller majority in House than the previous Congress, with the balance currently at 222(D)-211(R), with two vacancies. Following Democrats' victories in the two U.S. Senate elections in Georgia on January 5, the chamber will be under Democratic control at 50(D)-50(R), with Vice President Harris acting as the tie-breaker.

On January 4, the House adopted its rules package for the 117th Congress on a 217-206 party-line vote. Among other provisions, the package allows the House Budget chair to exempt climate change and COVID-related legislation from pay-as-you-go (PAYGO) rules, which may make it easier for progressives to bring expensive bills to the floor.

With a narrow majority now in the Senate, Democrats may seek to pass spending and tax-related measures through budget reconciliation procedures, which require only a simple majority to advance legislation. Legislation passed via reconciliation must have direct budgetary effects and not increase the deficit after 10 years. Budget reconciliation was used to pass the Tax Cuts and Jobs Act (TCJA) in 2017 and the Affordable Care Act (ACA) in 2010, and Democrats could use the process to advance tax- and ACA-related proposals.

Health-related items that may be considered in a reconciliation process may include the following priorities for the Biden-Harris Administration, among others:

- Expansion of income eligibility for Affordable Care Act (ACA) premium tax credits;
- Increasing the size of premium tax credits;
- Allowing Medicaid-eligible individuals in non-expansion states to receive premium tax credits;
- Increasing the Medicaid Federal Medical Assistance Percentage (FMAP) rate;
- Drug pricing proposals (e.g., allowing Medicare to negotiate prescription drug prices);

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- Increasing COBRA premium subsidies;
- Creation of a public option or Medicare early buy-in plan; and
- Other investments to strengthen health care system infrastructure and preparedness.

Tax increases could be used to offset new spending, and progressives have mentioned the possibility of using reconciliation to advance "tax fairness."

Health Care Outlook

Upon taking office, President Biden's top priority will be COVID-19 response and vaccine distribution. On January 14, President-elect Biden released the outline of a $1.9 trillion COVID-19 relief plan that he has been developing with congressional Democrats. The plan calls for sending $1400 checks to individuals and families, which would be in addition to the $600 rebates included in the year-end omnibus package.

The Biden plan also would:

- Invest $50 billion for an expansion of COVID-19 testing;
- Create a national vaccination program for the distribution and administration of COVID-19 vaccines;
- Invest $30 billion into the Disaster Relief Fund for medical supplies and protective gear;
- Direct $350 billion in aid to state and local governments;
- Increase and expand ACA premium tax credits;
- Extend until September 30, 2021 the emergency paid leave requirements that expired at the end of 2020;
- Provide additional grants and loans to struggling small businesses;
- Provide funding to schools to reopen safely; and
- Increase the federal minimum wage to $15.

The outline also states that President-elect Biden will work with Congress to increase the Medicaid Federal Medicaid Assistance Percentage (FMAP) to 100 percent for the administration of vaccines.

The incoming Administration has signaled a desire to advance the package with bipartisan support, though Republicans are likely to object to the nearly $2 trillion price tag.

Other top health care priorities for the Biden Administration including strengthening the ACA, addressing racial and ethnic health care disparities, and lowering prescription drug prices. Democrats' majority in the Senate may put other health care policies within reach, such as incentivizing Medicaid expansion and rescinding the Republican lawsuit against the ACA.

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The new Administration will likely reverse in short order a number of regulations and executive orders advanced by the Trump Administration, such as Trump's Section 1332 guidance and activities that promote the sale of ACA-noncompliant policies. The Biden Administration is likely to reverse Trump's executive order that promotes the use of work requirements to qualify for Medicaid and to repeal Trump era sub-regulatory guidance on Medicaid block grants and community engagement requirements. In addition, Democrats may be able to use the Congressional Review Act (CRA) to overturn recently issued regulatory actions, including any "midnight" rulemaking related to health care.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

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

January 19, 2021

CalOptima Board of Directors Report
Edelstein Gilbert Robson & Smith LLC
By Don Gilbert, Trent Smith and Bridget McGowan

Last week, Governor Newsom unveiled his proposed $227 billion 2021-2022 budget.

As the Governor noted himself, the last 12 months have been a financial roller coaster for the state. Coming into 2020, the Governor enjoyed a large budget surplus and healthy reserves. Soon after the state's response to the pandemic intensified in March, revenues were expected to plummet, and the Governor and Legislature believed that they were facing a massive $54 billion deficit. The 2020 budget reflected that expectation.

However, state revenues have been stronger than anticipated. The state has been extremely reliant on high income earners and capital gains revenue for years. While this has historically been a driver for the state's infamous boom and bust budgeting cycle, state revenue has remained steadier than expected through the pandemic since many high-income earners have continued to earn from home without interruption. As such, the state outperformed the expectations of the 2020 budget and is entering 2021 in a far better state than expected.

Overview of Governor's Budget

$15.5 Billion Windfall

The Governor's Budget anticipates a $15.5 billion one-time surplus. Not surprisingly, the Governor proposes to use most of this revenue to support one-time expenses including repayment of debt, direct stimulus payments to low-income tax payers, combatting homelessness, combatting COVID-19, and providing assistance to small businesses.

Rebuilding Reserves

The 2020-2021 budget year left $11.4 billion in reserves. The Governor's Budget proposes to increase reserves to $18.9 billion.

However, it is worth noting that most of the proposed increase in reserves is required by the Constitution. Discretionary increases in reserves only amount to $267 million in the Governor's budget.

Operating Deficits in Future Years

Not all of the news in the Governor's Budget was good. The Department of Finance (DOF) projects that revenue growth will not keep pace with the growth in expenses in future years. This means that the state could be facing an operating deficit of $7.6 billion in the next budget year which would grow to $11.3 billion in the 2024-2025 budget year.

Accelerated Spending
The Constitution requires the Legislature to conclude its negotiations and pass a budget by June 15. Typically, new spending approved as part of the budget does not become available until the start of the new fiscal year on July 1.

The Governor is proposing $12.8 billion of accelerated funding in his Proposed Budget. He has asked the Legislature to approve $5 billion in the coming weeks which includes $2 billion in grants to schools to incentivize in-person learning, $2.5 billion to provide $600 tax refunds to low-income Californians, and $550 million for small business loans and grants. In addition, the Governor has asked the Legislature to approve $7.8 billion by early spring, most of which would go to education, combatting homelessness, and meeting the Governor's recently adopted goals to sell more zero emission vehicles.

In order to accommodate the Governor's proposal, the Legislature must approve this accelerated spending on a 2/3 vote. While Democrats in the Legislature hold more than enough seats to meet this threshold on paper, the 2/3 vote threshold could provide leverage to Democrats who are critical of the Governor's plan.

Observations

Minimal Investments in Reserves
The Governor and the Legislature must balance the immediate needs of Californians suffering from the impacts of the pandemic with the reality of looming budget deficits. The Governor's Budget puts the emphasis almost entirely on immediate needs by investing little more than what is required in reserves. If these reserves are not sufficient to offset future deficits, the Legislature and Governor will be forced to consider spending cuts or increased taxes to balance the budget in future years.

How Long will the Proposed Budget be Relevant?
The Governor's Office finalized the budget just as Congress was passing another sweeping pandemic relief bill. Consequently, many of the Governor's pandemic relief proposals are arguably duplicative of what will be provided through federal funding.

At the same time, on Thursday night, President-Elect Biden unveiled his plans for another $1.9 trillion package. The latest round of federal funding, combined with future stimulus, while welcome, could render otherwise solid spending proposals in the Governor's budget a poor use of limited state funds.

While there is usually a lot of pressure on Democrats in the Legislature to defer to the Governor on budget issues, there is the chance that the specter of redundant spending will give them pause when considering the Governor's proposal for accelerated spending. Legislators could thread the needle by appropriating the funds ass requested, but include a contingency triggered if the state receives federal funding for the same purpose.

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No New Revenue Proposals
The Governor's Budget does not include new taxes. Raising taxes is politically challenging for a Democratic caucus that has built supermajorities by winning seats historically held by Republicans. They're also tricky for a Governor who could be facing a recall election and will be up for reelection in 2022 regardless.

Accelerated Spending
The Governor's desire to use surplus revenue to stimulate the economy and support those struggling through the pandemic is understandable. However, the Legislature has a well earned but poor track record when it comes to adopting legislation on a tight time frame. It is not uncommon for the Legislature to have to revisit its work to clean up or correct errors when it has passed legislation without a thorough vetting.

The Governor is proposing billions in spending to be approved in the coming weeks, and even more in a few months. It is unclear whether this timeframe will allow the Legislature to thoroughly evaluate the Governor's proposals.

Medi-Cal and Health Care Spending
The Governor's proposed budget included a lot of good news in the areas of Medi-Cal and health care spending. As we previously mentioned, the 2020-21 budget included several cuts, including many health care spending reductions. However, many of these cuts have been restored or delayed.

For example, Medi-Cal plans were scheduled to absorb a 1.5% rate reduction. However, these cuts are not part of the current budget.

Funding reductions in Proposition 56 (Tobacco Tax) funded programs and payments have been delayed by one year to July 1, 2022.

Full payments for the Behavioral Health Integration program, the AIDS waiver, Home Health, and Pediatric Day Health will be restored for the current fiscal year. Women's Health, Family Planning, will also receive full funding this year.

Medi-Cal optional benefits scheduled for elimination, including audiology and speech therapy services, incontinence creams and washes, optician and optical lab services, and podiatric services will be maintained until at least December 31, 2022. In addition, continuous glucose monitors will be added as a covered Medi-Cal benefit for adult individuals with type 1 diabetes, effective January 1, 2022. Adult Acetaminophen and Cough/Cold products are also reinstated as a Medi-Cal benift.

Two years ago, the Governor proposed California Advancing and Innovating Medi-Cal (CalAIM), a multi-year program to improve the quality of life and health outcomes by implementing broad delivery system, program, and payment reforms across the Medi-Cal program. However, implementation of CalAIM was delayed last year because of uncertain state revenues. This year's budget includes $1.1 billion in 2021-22, $1.5 billion in 2023-24, and $846.4 million ongoing to implement CalAIM, consistent with the

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proposals contained in the Governor's 2020 January budget proposal. Specifically, funding will be used to enhance care management and in lieu of services, infrastructure to expand whole person care statewide, and build upon dental initiatives.

We also expect discussions to advance between health plans and DHCS regarding development of a statewide health information exchange designed to enhance the sharing and evaluation of health care data needed to develop better services. We also believe there will be a focus on adopting new permanent telehealth policies, similar to those adopted to address the COVID-19 pandemic.

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2021–22 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 93 Garcia	**Prioritization of Food Supply Industry Workers:** Would prioritize workers in the food supply industry, such as field workers and grocery workers, for rapid testing and vaccination programs in response to pandemics, including COVID-19.	**12/07/2020** Introduced	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 77 Petrie-Norris	**Jarrod's Law:** States the intent of the author to introduce legislation that would require the California Department of Health Care Services (DHCS) to administer a licensing process for inpatient and outpatient substance use disorder treatment programs that are not otherwise required to be licensed under current law.	**12/07/2020** Introduced	CalOptima: Watch
SB 106 Umberg	**Mental Health Services Act (MHSA) Focus Populations:** States the intent of the author to introduce legislation that would update the MHSA to further address individuals with mental illness who are also experiencing homelessness or are involved in the criminal justice system. Updates to the MHSA would also address early intervention efforts for youth experiencing a mental illness.	**01/05/2021** Introduced	CalOptima: Watch

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 114 Maienschein	**Rapid Whole Genome Sequencing:** Would add rapid Whole Genome Sequencing as a covered Medi-Cal benefit. The benefit would include individual sequencing, trio sequencing for parents and their baby, and ultra-rapid sequencing.	**12/17/2020** Introduced	CalOptima: Watch

ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Legislative Analyst's Office previously projected this expansion would cost approximately $900 million General Fund (GF) in 2019-2020 and $3.2 billion GF each year thereafter, including the costs of In-Home Supportive Services.	**12/07/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 112 Holden	**Inmate Eligibility Extension:** Would delay the termination date of Medi-Cal eligibility for non-juvenile inmates from one (1) year of elapsed incarceration to three (3) years of elapsed incarceration. For juvenile inmates, Medi-Cal eligibility would not be terminated until three (3) years after their status as a juvenile has ended. While Medi-Cal benefits and payments would still be suspended throughout incarceration, as required by federal law, this bill would allow inmates to remain Medi-Cal eligible for a longer period before termination. The lengthened eligibility period would allow more inmates to immediately reinstate their benefits upon release, rather than initiate the standard re-determination process.	**12/17/2020** Introduced	CalOptima: Watch
SB 56 Durazo	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 65 years or older, regardless of their immigration status. The Assembly Appropriations Committee projects this expansion would cost approximately $134 million each year ($100 million GF, $21 million federal funds) for approximately 25,000 undocumented seniors. The financial costs for In-Home Supportive Services is estimated to cost $13 million GF.	**12/07/2020** Introduced	CalOptima: Watch

HOMELESSNESS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 71 Rivas, Luz	**Statewide Homelessness Solutions Program:** States the intent of the author to introduce legislation that would create a comprehensive, statewide homelessness solutions program. The program would facilitate collaboration across all levels of government and create additional flexibilities to accelerate the transition of homeless individuals into permanent housing. Would also create the Bring California Home Fund in the State Treasury to provide at least $2.4 million annually to fund the statewide homelessness solutions program, subject to appropriation by the Legislature. Funds must be derived from specific adjustments in the personal income tax and/or corporate income tax structures.	**12/07/2020** Introduced	CalOptima: Watch

POPULATION HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 17 Pan	**Racism as a Public Health Crisis:** Would require the California Department of Public Health (CDPH) to collaborate with the Office of Health Equity, Health in All Policies Program, and other departments and stakeholders to address racism as a public health crisis.	**12/07/2020** Introduced	CalOptima: Watch

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 97 Nazarian	**Insulin Affordability:** States the intent of the author to introduce legislation that would make insulin more affordable for Californians.	**12/08/2020** Introduced	CalOptima: Watch

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 40 Hurtado	**California Medicine Scholars Program:** Would require California's Office of Statewide Health Planning and Development (OSHPD) to establish the California Medicine Scholars Program (CMSP) as a five-year pilot program, effective January 1, 2023. In order to address the shortage of primary care physicians and the growing health disparities in underserved communities, the CMSP would serve as a pipeline for community college students to pursue premedical training and enter medical school. The CMSP would be administered by a contracted entity through four regional hubs, each comprised of a four-year university, medical school, community colleges, and local organizations.	**12/17/2020** Introduced	CalOptima: Watch

SUBSTANCE USE

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 75 Bates	**Southern California Fentanyl Task Force:** Would establish the Southern California Fentanyl Task Force, under the direction of the Attorney General, to identify strategies to combat the fentanyl crisis. The task force would be comprised of representatives from the California Department of Justice (DOJ), California Highway Patrol (CHP) and each County within Southern California. Would require the task force to hold its first meeting by July 1, 2022, and issue a report of its findings and recommendations to the Legislature and DOJ by January 1, 2025.	**12/15/2020** Introduced	CalOptima: Watch

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 32 Aguiar-Curry	**Telehealth Payment Parity and Flexibilities:** Would expand current law to require Medi-Cal managed care plans, including County Organized Health Systems (COHS), to reimburse its contracted providers for telehealth services at the same rate as equivalent in-person health services. This requirement would also apply to any delegated entities of a Medi-Cal managed care plan, such as contracted health networks. Would allow providers to determine eligibility and enroll patients into Medi-Cal programs through audio-visual or audio-only telehealth services. Additionally, would require DHCS to indefinitely continue all telehealth flexibilities implemented during the COVID-19 pandemic. DHCS would be required to establish an advisory group to guide the development a long-term Medi-Cal telehealth policy.	**12/07/2020** Introduced	CalOptima: Watch

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

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

Last Updated: January 13, 2020

2021 Federal Legislative Dates

January 3	117th Congress, 1st Session convenes
March 29–April 9	Spring recess
August 2–27	Summer recess for House
August 9–September 10	Summer recess for Senate
December 10	1st Session adjourns

2021 State Legislative Dates*

**Due to COVID-19, 2021 State Legislative dates have been modified*

January 11	Legislature reconvenes
February 19	Last day for legislation to be introduced
March 25–April 4	Spring recess
April 30	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in their house
May 7	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in their house
May 21	Last day for fiscal committees to hear and report to the floor any bills introduced in their house
June 1–4	Floor session only
June 4	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills to fiscal committees or the floor
July 16–August 15	Summer recess
August 27	Last day for fiscal committees to report bills to the floor
August 30–September 10	Floor session only
September 3	Last day to amend bills on the floor
September 10	Last day for bills to be passed; final recess begins upon adjournment
October 10	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2021 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

CalOptima, a county organized health system (COHS), is the single plan providing guaranteed access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

Board of Directors Meeting
February 4, 2021

CalOptima Community Outreach Summary — December 2020 and January 2021

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

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

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

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

CalOptima Community Event Update
The Community Relations and Case Management departments hosted CalOptima's Community Resource Fair for employees and health care partners through a virtual four-part series that focused on Resources for Individuals Experiencing Homelessness. Twenty community organizations were invited to present and share information about programs and services in the areas of health, legal resources, veteran services, general resources and basic needs.

Despite not being able to visit resource tables in person, the event was very well received and attracted 147 unique attendees, with an average of 73 attendees per session. In lieu of having resource tables, we invited organizations to provide presentations on their programs and services with a Question and Answer portion. Based on results from the event survey, most participants shared they prefer a virtual format over the in-person event. One participant shared, "Great fair! I thoroughly enjoyed listening to all the presenters. Great way to connect with our community resources! Please keep it up and continue to offer resource fairs." Another participant shared, "I prefer an in-person resource fair, however, due to the COVID-19 pandemic, having a virtual resource fair is ideal during this challenging time. Presenters were outstanding. I learned a lot from today's presentation and will share the slides with my team members."

The Community Relations and Case Management departments are dedicated to supporting staff and health care partners and increasing knowledge of community resources to support our members' comprehensive needs. For

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additional information or questions, contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

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

As of December 14, 2020, **through virtual meetings and teleconferences**, CalOptima expects to participate in 50 community events, coalition and committee meetings during December 2020 and January 2021.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
12/01/2020	• Homeless Consortium — Together We Can: Expanding the Conversations Surrounding Homelessness & Vulnerable Populations hosted by the Illumination Foundation (Sponsorship fee: $1,000 included sponsor agency's logo listed in PDF event program, on registration page and pre-event e-blast, and on social media post-event gratitude post) (Virtual Conference)
12/02/2020	• Anaheim Human Services Network Meeting (Virtual Meeting) • Orange County Healthy Aging Initiative/Orange County Strategic Plan for Aging Healthcare Committee Meeting (Virtual Meeting)
12/03/2020	• Garden Grove Community Collaborative Advisory Meeting (Virtual Meeting)
12/08/2020	• Orange County Cancer Coalition Meeting (Virtual Meeting) • Wellness and Prevention Coalition Meeting (Virtual Meeting)
12/09/2020	• Anaheim Homeless Collaborative Meeting (Virtual Meeting)
12/10/2020	• Buena Park Collaborative Meeting (Virtual Meeting) • Kid Healthy Community Advisory Committee Meeting (Virtual Meeting)
12/14/2020	• Stanton Collaborative Meeting (Virtual Meeting) • Orange County Veterans and Military Families Collaborative — Children and Family Working Group (Virtual Meeting) • Fullerton Collaborative Meeting (Virtual Meeting)
12/15/2020	• Placentia Community Collaborative Meeting (Virtual Meeting) • Aging and Disability Resource Connection Advisory Committee Meeting (Virtual Meeting)
12/16/2020	• Covered Orange County Steering Committee Meeting (Virtual Meeting) • Orange County Communications Workgroup (Virtual Meeting) • Minnie Street Family Resource Center Professional Roundtable (Virtual Meeting)

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	• Orange County Virtual Resource Fair: Care Coordination and More hosted by Aurrera Health Group (Virtual Event)
12/21/2020	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting (Virtual Meeting)
1/05/2021	• Collaborative to Assist Motel Families (Virtual Meeting) • Orange County Women's Health Project Advisory Meeting (Virtual Meeting)
1/06/2021	• Stanton Collaborative Meeting (Virtual Meeting) • Anaheim Human Services Network Meeting (Virtual Meeting)
1/07/2021	• Continuum of Care Homeless Provider Forum (Virtual Meeting) • Garden Grove Community Collaborative Advisory Meeting (Virtual Meeting)
1/08/2021	• Senior Citizens Advisory Council General Meeting
1/11/2021	• Orange County Veterans and Military Families Collaborative — Children and Family Working Group (Virtual Meeting) • Fullerton Collaborative Meeting (Virtual Meeting) • Be Well Older Adult Workgroup (Virtual Meeting)
1/12/2021	• Orange County Cancer Coalition Meeting (Virtual Meeting) • Wellness and Prevention Coalition Meeting (Virtual Meeting)
1/13/2021	• Anaheim Homeless Collaborative Meeting (Virtual Meeting) • Health Care Task Force (Virtual Meeting)
1/14/2021	• Buena Park Collaborative Meeting (Virtual Meeting) • Garden Grove Collaborative Meeting (Virtual Meeting) • Kid Healthy Community Advisory Committee Meeting (Virtual Meeting) • State Council on Developmental Disabilities Regional Advisory Committee Meeting (Virtual Meeting)
1/18/2021	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting (Virtual Meeting)
1/19/2021	• North Orange County Senior Collaborative All Members Meeting (Virtual Meeting) • Placentia Community Collaborative Meeting (Virtual Meeting) • Aging and Disability Resource Connection Advisory Committee Meeting (Virtual Meeting)
1/20/2021	• Covered Orange County Steering Committee Meeting (Virtual Meeting) • Orange County Communications Workgroup (Virtual Meeting) • Minnie Street Family Resource Center Professional Roundtable (Virtual Meeting)

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1/21/2021	• Orange County Women's Health Project Advisory Meeting (Virtual Meeting)
1/25/2021	• Stanton Collaborative Meeting (Virtual Meeting)
1/26/2021	• Clinic in the Park Collaborative Meeting (Virtual Meeting)
1/27/2021	• Orange County Strategic Plan for Aging Leadership Council Meeting (Virtual Meeting)
1/28/2021	• Orange County Care Coordination for Kids Collaborative Meeting (Virtual Meeting)

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff/ Volunteer to Attend	Events/Meetings
12/05/2020	NA	• Winter in the Grove hosted by City of Garden Grove (Sponsorship fee: $1,000 included resource table at the event, agency's logo on event banner and city's social media platforms (Drive-thru Event)

As of December 14, 2020, CalOptima expects to organize or convene six community stakeholder events, meetings or presentations through virtual meetings or teleconferences during December 2020 and January 2021.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
12/01/2020	• Cafecito Meeting (Virtual Meeting)
12/03/2020	• CalOptima Resource Fair — Basic Needs for Individuals Experiencing Homelessness (Virtual Event)
12/09/2020	• Community Alliances Forum — Mental Health and Self-Care During Uncertain Times (Virtual Event) • Community-Based Organization Presentation — Topic: CalOptima Medi-Cal 101 and Clinical Field Teams (English Virtual Presentation)
12/17/2020	• Health Network Forum (Virtual Meeting)
1/21/21	• Health Network Forum (Virtual Meeting)

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As of December 14, 2020, CalOptima expects to provide one endorsement consistent with CalOptima Policy AA. 1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo (e.g., letters of support, program/public activity events with support or use of name/logo).

1. Letter of Support to Mind OC for ACEs Aware Trauma-Informed Network of Care Implementation Grant

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CalOptima Board of Directors
Community Activities

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

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term partnership between CalOptima and the requesting entity.

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

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

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

In response to the COVID-19, CalOptima has transitioned how we engage with our community partners and is not attending in-person community collaborative meetings. In addition, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19. CalOptima continues its participation in community collaborative meetings and community events by attending virtual meetings and events; CalOptima also looks for additional ways to support our community partners by providing CalOptima informing materials and, if requested and criteria are met, by providing branded items. With respect to events that have been cancelled or postponed due to COVID-19 in which sponsorship or fees have already been paid, event organizers were provided the option to refund previously pre-paid participation fees or apply paid sponsorship fees to any future events, provided the future event(s) meet the criteria set forth in Policy AA.1223 and meets eligibility requirements indicated by Board of Directors.

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

February

Date and Time	Event Title	Event Type/Audience	Staff/ Financial Participation	Location
Tuesday, 2/2 9:30–11 a.m.	++ Collaborative to Assist Motel Families Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 2/3 10 a.m.–12 p.m.	++ OC Aging Services Collaborative General Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 2/3 10 a.m.–12 p.m.	++ Anaheim Human Services Network Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 2/3 10:30 a.m.–12 p.m.	++ Orange County Healthy Aging Initiative/OCSPA Healthcare Committee	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 2/4 9–11 a.m.	++ Continuum of Care Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 2/4 11 a.m.–1 p.m.	++ Garden Grove Community Collaborative Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Monday, 2/8 1–2:30 p.m.	++Orange County Veterans and Military Families Collaborative - Children and Family Working Group	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Monday, 2/8 2:30–3:30 p.m.	++Fullerton Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 2/9 10–11:30 a.m.	++Orange County Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format

Tuesday, 2/9 3:30–5:30 p.m.	++Wellness and Prevention Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 2/10 12–1:30 p.m.	++Anaheim Homeless Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 2/11 10:00–11:30 a.m.	++Buena Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 2/11 11:30 a.m.–12:30 p.m.	++Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 2/11 12:30–1:30 p.m.	++Kid Healthy Community Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Conference call
Friday, 2/12 9–11 a.m.	++Senior Citizens Advisory Council General Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Monday, 2/15 1–4 p.m.	++ OCHCA Mental Health Services Act Steering Committee Meeting	++ OCHCA Mental Health Services Act Steering Committee	1 Staff	Virtual format
Tuesday, 2/16–2/19 8:30–10 a.m.	+ UCI Paul Merage School of Business 30th Annual Health Care Forecast Conference	Conference Registration required	Sponsorship $1,000 13+ Staff	Virtual format
Tuesday, 2/16 11 a.m.–12 p.m.	++Placentia Community Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 2/16 1-2:30 p.m.	++Aging and Disability Resource Connection Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 2/17 9–10:30 a.m.	++ Covered Orange County Steering Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Conference call
Wednesday, 2/17 11 a.m.–12 p.m.	++Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format

Wednesday, 2/17 3:30–4:30 p.m.	++ Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Conference call
Thursday, 2/18 9–11:00 a.m.	*Health Network Forum	Steering Committee Meeting: Open to Collaborative Members	10+ Staff	Virtual format
Monday, 2/22 9–11 a.m.	++Community Health Research Exchange	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Monday, 2/22 12:30–1:30 p.m.	++Stanton Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 2/23 9–10:30 a.m.	++Clinic in the Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 2/24 9–10:30 a.m.	*Cafecito Meeting	Steering Committee Meeting: Open to Collaborative Members	3 Staff	Virtual format
Thursday, 2/25 1:30–3:30 p.m.	++ Orange County Care Coordination for Kids Meeting	Steering Committee Meeting: Open to Collaborative Members	2 Staff	Virtual format

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
18. Consider Actions Related to Implementation of CalOptima's COVID-19 Vaccine Strategy

Contacts
Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, (714) 246-8887
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8574

Recommended Actions
1. Authorize participation in the County of Orange's COVID-19 Vaccine Equity Pilot Program, and coordination with the Orange County Health Care Agency for implementation of a portion of CalOptima's COVID-19 Member Vaccine Incentive Program;

2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a contract or contract amendments, and data sharing arrangement with the County of Orange as appropriate, subject to regulatory approvals as necessary for distribution of CalOptima's COVID-19 member incentive; and

3. Authorize the Chief Executive Officer to coordinate with the County of Orange and other CalVax-authorized providers to organize vaccination events for CalOptima Members, and with the assistance of Legal Counsel, to enter into any necessary contracts or contract amendments with those providers.

Background
On January 7, 2021, the CalOptima Board of Directors approved a COVID-19 Vaccination Member Incentive Program for calendar year 2021 (see Attachment 1), the goal of which is to encourage Members, through the provision of nonmonetary gift cards, to get the COVID-19 vaccination. CalOptima is required to obtain approval for the related texting campaign and for member incentive programs from the California Department of Health Care Services (DHCS). CalOptima has since sought such approvals and has received authorization for the member incentive program. The texting campaign is currently pending DHCS approval, and staff will seek any additional required approvals.

CalVax is the system operated by the California Department of Public Health through which health care providers enroll to be allocated vaccines. COVID-19 vaccines are allocated to the counties, as well as to various community providers approved to receive and administer the vaccine through CalVax. An essential part of CalOptima's COVID-19 vaccination strategy is coordination with the County of Orange and various CalVax-approved providers to organize vaccination events and ensure that CalOptima Members have access to the vaccines when members' respective vaccination tiers are authorized by the State.

Discussion
The County of Orange is encouraging both residents and providers to utilize the Othena app platform to make vaccination appointments. This app was developed to help healthcare providers track vaccine recipients and dosages. CalOptima staff has been in communication with the Orange County Health

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Care Agency (OCHCA) to ensure that CalOptima members have appropriate access to COVID-19 vaccines.

On January 26, 2021, the Orange County Board of Supervisors took several actions directing OCHCA to collaborate with CalOptima on the establishment of the County's COVID-19 Vaccine Equity Pilot Program (VEPP). This pilot is designed to provide CalOptima's vulnerable senior members, as identified by CalOptima and their Health Networks through encounter data, direct access to the COVID-19 vaccine. VEPP is specifically designed for members who belong to Health Networks that do not receive a direct vaccine distribution from the state. If a network subsequently starts to receive direct allocations from the state, their members will not be eligible for participation in this program.

Members will be encouraged, but not required, to sign up with the no cost Othena platform, the OCHCA's appointment system. Because OCHCA's access to vaccination data is through the Othena platform, CalOptima staff is seeking Board authorization to take necessary steps to participate with the OCHCA, including contracting with (or amending an existing County contract) and entering into data sharing arrangements, as appropriate, as well as obtaining any necessary additional DHCS' approvals, to facilitate distribution of Board-approved member incentives. In addition, CalOptima plans to maintain a means of distributing the incentives independent of the Othena platform for Members who obtain vaccination through channels other than the Othena application. For Members who have difficulty accessing the Othena platform, CalOptima Customer Service staff are poised to provide support.

In addition to CalOptima's Member vaccination incentive program, the County recently established the COVID-19 VEPP to provide vaccination support to CalOptima's vulnerable populations within the currently eligible tiers. As illustrated in CalOptima's geo mapping data (Attachment 2), members aged 65 or older primarily reside in approximately 15 zip codes across the county, with majority of the identified zip codes are in the cities of Santa Ana, Anaheim, Garden Grove and Westminster, which happen to be the county's hardest hit communities by COVID-19. Staff is evaluating geo mapping and zip code data, along with encounter information, as part of overall efforts to ensure that all eligible Members have an opportunity to receive vaccination when their tier is authorized. In a process outlined by OCHCA, CalOptima will provide OCHCA with a list of recommended providers for direct vaccine allocation that will be used for the identified CalOptima population, specifically. CalOptima staff are prioritizing its members in the CCN/COD Health Networks and will work with the remaining networks to provide additional vaccination allocation support based on responses received to a Health Network survey. Staff are prepared to provide direct outreach and transportation support to CalOptima members when providers begin receiving direct allocations from OCHCA.

In addition to the Health Network approach, CalOptima plans to establish separate vaccination events throughout the community (using data to inform event locations) to ensure that members have several venues to secure a vaccination. At these events, CalOptima will work with its community partners to have additional resources on-site (e.g., transportation, housing navigation, food resources, etc.). All of the above strategy is dependent on allocation from OCHCA to CalOptima's identified providers.

As indicated, CalOptima staff will continue to work closely with OCHCA to track Member vaccinations, subject to any required data sharing arrangements and regulator approvals.

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Fiscal Impact

There is no fiscal impact to Recommended Actions 1 and 2. Funding for Recommended Action 3 is included under the Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020 as part of the Community Relations budget. If additional funding is needed to support CalOptima's vaccine efforts, staff will return to the Board with further recommendations.

Rationale for Recommendation

The recommended actions are intended to facilitate the implementation of the Board-approved vaccination incentive programs, and ensure that CalOptima's most vulnerable populations have access to COVID-19 vaccinations. Taken together, these and other actions will address health disparities, continue providing access to quality health care for members during the COVID-19 public health crisis, and assist the county in reaching herd immunity.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Board Action Dated January 7, 2021, Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021
3. COVID-19 Geo Mapping Data

/s/ Richard Sanchez — *01/28/2021*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Orange County Health Care Agency	405 W. 5th Street	Santa Ana	CA	92701
Composite Apps, Inc. (Othena Application)	100 Spectrum Center Drive, Suite 250	Irvine	CA	92618
CalVax	https://www.calvax.org/			

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 7, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021

Contacts

Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, 714-246-8887
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8574
Ladan Khamseh, Chief Operating Officer, (714) 246-8866

Recommended Actions

1. Authorize the development and implementation of a COVID-19 Vaccination Incentive Program (VIP) for Calendar Year (CY) 2021, as described below, to increase member participation and ensure community safety amid the COVID-19 pandemic, subject to DHCS approval prior to implementation;
2. Approve the recommended allocation of Intergovernmental Transfer (IGT) 10 funds, not to exceed $20 million, to provide two $25 nonmonetary gift cards to individual Medi-Cal members age 14 and older for receiving the two required doses of the COVID-19 vaccine (one gift card per shot); and
3. Authorize implementation of the VIP prior to CalOptima's receipt of IGT 10 funds from the State of California.
4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into an Memorandum of Understanding (MOU), and/or contract or contract amendment with the Orange County Health Care Agency (OCHCA) as appropriate for administration and implementation of the VIP.

Background

In late December 2020, the first doses of the COVID-19 vaccines arrived in Orange County. Vaccines will be distributed according to a phased approach, with high-priority groups vaccinated first and eventually the general public as determined by the California Department of Public Health and local health department. The U.S. Food and Drug Administration issued an emergency use authorization (EUA) for the Pfizer-BioNTech and Moderna vaccines, both of which offer more than 94% protection against COVID-19 when two doses are taken. Public health experts recommend that at least 70% of the population needs to get vaccinated to develop herd community, which can bring an end to the pandemic.

As the only Medi-Cal plan serving Orange County's most vulnerable residents, CalOptima is responding in collaboration with the Orange County Health Care Agency (OCHCA) to support the community in achieving herd immunity. The first step is a strategy that promotes COVID-19 vaccination, including tailoring member education on the importance of vaccination, dispelling misconceptions, and providing nonmonetary member incentives to ensure health equity across race, ethnicity and socioeconomic status. To support this effort, CalOptima staff is seeking an allocation of IGT 10 funds.

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities, which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in ten Voluntary Rate Range IGT transactions. Funds from IGTs 1 through 9 have been

received, and IGT 10 funds will be distributed in two separate installments, which are expected from the state in 2021.

Discussion

Subject to state approval, staff will work with various internal and external partners on a member outreach program that provides COVID-19 vaccine information. The proposed program includes:

1. A mailing to all members with information about the vaccine.
2. A targeted text messaging campaign. When different priority groups are permitted to be vaccinated, CalOptima will send out targeted text messages to these members letting them know the following:
    a. They are now eligible to be vaccinated.
    b. Where they need to go to be vaccinated. (This information is not yet available, but staff continue to work with OCHCA to establish vaccine events in targeted geographic locations within the county. The vaccine events are likely to begin in Spring 2021, but may extend into the fall, depending on the vaccine distribution timeline as established by OCHCA.)
3. A targeted phone call campaign to population segments who are at high risk for not getting vaccinated. This will begin once the vaccine is widely available to at least essential workers, according to the phased approach.

Staff projects that as many as 400,000 members will participate in this program. To encourage members to participate in vaccination, staff proposes to provide two $25 nonmonetary gift cards for Medi-Cal members age 14 and older for receiving each of two doses of the COVID-19 vaccine, for a total of $50. Members will be encouraged to sign up with the OCHCA's app, Othena, at no cost, to receive the gift card incentives, one gift card for each shot received. The app is being developed to help healthcare providers track vaccine recipients to ensure they get a booster shot and to monitor for side effects. Staff is also seeking authority to enter into a Memorandum of Understanding (MOU) and/or contract or contract amendment with the County as necessary to implement the program. If it is subsequently determined that agreements with other entities, organizations or vendors are necessary, staff will return to the Board with further recommendations for consideration at a later date.

The targeted timeframe for the COVID-19 nonmonetary incentive is CY 2021. IGT 10 funds have not yet been received. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing member's unmet health care needs. It is anticipated that CalOptima's share of IGT 10 funds will be approximately $66 million ($43.3 million in Spring 2021 and $22.7 million in Fall 2021).

Due to timing issues, staff requests that the Board authorize the CEO to implement the COVID-19 Vaccination Incentive Program for CY 2021 prior to CalOptima's receipt of IGT 10 funds from DHCS. Providing the nonmonetary incentive to coincide with the availability of the COVID-19 vaccination to members will support CalOptima's health promotion efforts in our community.

It should be noted that since IGT 10 funds are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from DHCS, to the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's administrative loss ratio (ALR), rather than the medical loss ratio (MLR).

Fiscal Impact

The recommended action to allocate up to $20 million in IGT 10 funds to support the COVID-19 Vaccination Member Incentive Program has no net fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff anticipates any cash expended to implement the program will be replenished when IGT 10 funds are received from DHCS. Expenditure of IGT funds is for restricted one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Staff recommends adding a COVID-19 vaccination member incentive component to CalOptima's preventive initiatives to educate and encourage member participation. The recommended actions will support CalOptima's efforts to help the community reach herd immunity, address health disparities, and continue providing access to quality health care for members during the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. CalOptima Board Action dated February 6, 2020, Consider Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rating Period 2019-20 (IGT 10)

/s/ Richard Sanchez — *12/31/2020*
Authorized Signature — **Date**

ENTITITES COVERED BY THIS RECOMMENDED ACTION

Legal Name	Address	City	State	Zip code
County of Orange	405 W. 5th Street, Suite 756	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rating Period 2019-20 (IGT 10)

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Authorize the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program:

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range IGT Program for Rating Period 2019-20 (IGT 10);
2. Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range IGT Program for Rating Period 2019-20 (IGT 10); and,
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 10 funds.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in eight Rate Range IGT transactions. Funds from IGTs 1 through 8 have been received and IGT 9 funds are expected from the state in the first quarter of 2020. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2010-11 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to CMS. These funds have been best suited for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.

The IGT funds received under IGTs 1 through 7 have supported special projects that address unmet healthcare needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds will be incorporated into the contract between DHCS and CalOptima for the current fiscal year. Unlike previous IGTs (1-7), beginning with IGT 8 funds must be used in the current rate year for CalOptima covered Medi-Cal services per DHCS direction. IGT 8 funds have been allocated to the Homeless Health Initiative. IGT 9 funds have not yet been received, nor allocated; CalOptima staff anticipates returning with recommendations on an allocation plan in a separate Board action; however, as indicated,

per DHCS, the use of these funds is limited to covered Medi-Cal benefits for existing CalOptima members.

For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing Member's unmet healthcare needs.

Discussion

On December 20, 2019, CalOptima received notification from DHCS regarding the Rating Period 2019 - 20 Voluntary Rate Range IGT Program (IGT 10). Unlike the prior IGTs, which covered the applicable twelve-month state fiscal year, IGT 10 covers eighteen months including the periods of July 1, 2019 through June 30, 2020 and July 1, 2020. through December 31, 2020. CalOptima's proposal, along with the funding entities' supporting documents are due to DHCS no later than February 19, 2020.

The five eligible funding entities from the previous IGT transactions have been contacted regarding their interest in participation in IGT 10. All five funding entities have informally indicated that they are interested in participation in the IGT program this year. The formal DHCS required Letter of Interest is due to CalOptima by February 14, 2020 for delivery to DHCS by February 19, 2020. These entities are:

1. University of California, Irvine,
2. Children and Families Commission of Orange County,
3. County of Orange,
4. City of Orange, and
5. City of Newport Beach.

Board approval is requested to authorize staff to submit the proposal letter to DHCS for participation in the 2019-20 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with each of the five proposed funding entities submitting a letter of interest (or their designated providers) for the purpose of securing available IGT funds. Consistent with the nine prior IGT transactions, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Staff will return to the Board with additional information regarding the IGT 10 transaction and a proposed expenditure plan for CalOptima's share of the net proceeds at a later date.

Fiscal Impact

The recommended actions to submit a proposal to DHCS and pursue IGT funding partnerships with five governmental funding entities for IGT 10 is expected to generate one-time IGT revenue that will be invested in covered Medi-Cal services for CalOptima members. As such, there is no net fiscal impact on CalOptima's current and future operating budgets.

Rationale for Recommendation

Consistent with the previous nine IGT transactions, submission of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2019-20 (IGT 10). Also, consistent with the 2020-22 Strategic Plan, it would increase funding to support delivery of covered Medi-Cal services for CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Board Action
2. Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

/s/ Michael Schrader — *01/28/2020*

Authorized Signature — **Date**

Attachment 1 to February 6, 2020 Board of Directors Meeting – Agenda Item 15

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Children and Families Commission of Orange County	1505 E. 17th Street, 230	Santa Ana	CA	92705
City of Newport Beach	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange	300 E. Chapman Avenue	Orange	CA	92866
Orange County Health Care Agency	405 W. 5th Street, 7th Floor	Santa Ana	CA	92701
University of California, Irvine UCI Health	333 City Blvd. West, Suite 200	Orange	CA	92868

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

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOME
GOVERNOR

DEC 2 0 2019

Nancy Huang
Interim Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: Rating Period 2019–20 (July 1, 2019 through December 31, 2020) Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Ms. Nancy Huang:

The Rating Period 2019-20 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service periods of July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020.

DHCS shall not direct the MCP's expenditure of payments received under the Rating Period 2019-20 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived: from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from

programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the Rating Period 2019-20 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR RATING PERIOD 2019-20:

MCPs should refer to the estimated Rating Period 2019-20 (service periods July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020) county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the Rating Period 2019-20 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. Note that for service periods July 1, 2019 through June 30, 2020 and July 1, 2020 through December 31, 2020, the Contribution (Non-Federal Share) amounts are based on Estimated Member Months, and the actual amounts may change based on actual enrollment. Note that for service period July 1, 2020 through December 31, 2020, the Contribution (Non-Federal Share) amounts are based on Projected Contribution PMPMs, and the actual amounts may change based on the risk adjustment process that DHCS uses as part of its rate development methodology.

If an MCP elect to participate in the Rating Period 2019-20 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the Rating Period 2019-20 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.
    2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
    3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for Rating Period 2019-20. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
    4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the Rating Period 2019-20 Voluntary Rate Range Program Supplemental Attachment described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** from each governmental funding entity included in the MCP's proposal to DHCS. The highlighted sections in the letter of interest form provided in Attachment A must be filled out completely and printed on the participating governmental funding entity's letterhead. A separate letter of interest must be provided for each county or rating region. An individual who is authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest.

- The MCP must distribute to governmental funding entities and ensure submission to DHCS, either by the MCP or the governmental funding entity, of the **Rating Period 2019-20 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Wednesday, February 19, 2020.

- The proposals and letters of interest are due to DHCS ***by 5pm on* Wednesday, February 19, 2020**. Please send a PDF copy of the required documents by e-

mail to Sandra.Dixon@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the Rating Period 2019-20 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the Rating Period 2019-20 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 345-8269 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,

Jennifer Lopez
Division Chief
Capitated Rates Development Division

Attachments

cc: Michael Schrader
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

ATTACHMENT A – LETTER OF INTEREST

Jennifer Lopez
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Lopez:

This letter confirms the interest of _Insert Participating Funding Entity Name, a governmental entity, federal I.D. Number _Insert Federal Tax I.D. Number, in working with Managed Care Plan's Name (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service periods of July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

_Insert Participating Funding Entity Name is willing to contribute approximately $_____ for the Rating Period 2019-20 (July 1, 2019 through December 31, 2020) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Signature

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Rating Period 2019-20 (July 1, 2019 through December 31, 2020)

Provider Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than February 19, 2020.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2018 - June 30, 2019.

	Charges	Costs	Payments from Health Plan*	Uncompensated Chares (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$	$
Outpatient				$	$
All Other				$	$
Total	$	$	$	$	$

* Include payments received and anticipated to be received for service dates of July 1, 2018 through June 30, 2019.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *(Yes / No)*

If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. Please provide the following information:

(i) The name of the entity transferring funds:

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding:

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of

(iv) Does the transferring entity have general taxing authority? *(Yes / No)*

If No, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. *(Yes / No)*

5. Comments / Notes

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ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

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CalOptima - Orange (HCP 506)
IGT - 2019/20 (July 2019 - June 2020)

	Total	50% FFP (Non-MCHIP,SPD and LTC)	88% FFP (MCHIP - 7/2019 to 9/2019)	76.5% FFP (MCHIP - 10/2019 to 6/2020)	BCCTP[3]	WCM[4]	93% FFP Optional Expansion (7/2019 - 12/2019)	90% FFP Optional Expansion (1/2020 - 6/2020)
Total Funds Available	$ 143,831,947	$ 60,609,553	$ 2,248,273	$ 6,744,806	$ 567,560	$ 20,884,320	$ 26,388,727	$ 26,388,708
Federal Match	$ 98,389,329	$ 30,304,777	$ 1,978,480	$ 5,159,777	$ 189,344	$ 12,465,598	$ 24,541,516	$ 23,749,837
Governmental Funding Entity's Portion	$ 45,442,618	$ 30,304,776	$ 269,793	$ 1,585,029	$ 378,216	$ 8,418,722	$ 1,847,211	$ 2,638,871
	31.6%	50.0%	12.0%	23.5%	66.6%	40.3%	7.0%	10.0%

Rate Categories[1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage[2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,271,664	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 15,356,449
Child - MCHIP 7/2019 - 9/2019	303,510	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,051,728
Child - MCHIP 10/2019 - 6/2020	910,531	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 6,155,190
Adult - non MCHIP	1,007,518	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 19,948,856
Adult - MCHIP 7/2019 - 9/2019	9,788	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 193,802
Adult - MCHIP 10/2019 - 6/2020	29,363	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 581,387
SPD	448,861	$ 814.48	$ 859.81	$ 45.33	$ -	$ 45.33	$ 20,346,869
SPD/Full-Dual	24,336	$ 205.34	$ 215.02	$ 9.68	$ -	$ 9.68	$ 235,572
BCCTP	7,026	$ 1,430.69	$ 1,511.47	$ 80.78	$ -	$ 80.78	$ 567,560
LTC	15,492	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 4,721,807
LTC - MCHIP 7/2019 - 9/2019	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC - MCHIP 10/2019 - 6/2020	27	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 8,229
LTC/Full-Dual	0	$ 6,630.57	$ 6,780.31	$ 149.74	$ -	$ 149.74	$ -
WCM	146,382	$ 1,876.85	$ 2,019.52	$ 142.67	$ -	$ 142.67	$ 20,884,320
Optional Expansion 7/2019 - 12/2019	1,394,753	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,388,727
Optional Expansion 1/2020 - 6/2020	1,394,752	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,388,708
	7,964,012	$ 333.59	$ 353.87	$ 20.27	$ 2.21	$ 18.06	$ 143,831,947

[1] The supplemental payments (Maternity, BHT and HEP C) and CCI population are not included in the rate range calculation.

[2] Other Departmental Usages decreases available rate range funding.

[3] BCCTP Federal Match is based on the portion of the population enrolleed in a BCCTP aid code associated with a FFP percentage of 65%.

[4] WCM Federal Match is based on the FFP percentage associated with the aid codes within each rating categories.

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CalOptima - Orange (HCP 506)
IGT - 2019/20 (July 2020 - December 2020)

	Total	50% FFP (Non-MCHIP and SPD)	76.5% FFP (MCHIP - 7/2020 to 9/2020)	65% FFP (MCHIP - 10/2020 to 12/2020)	BCCTP [3]	WCM [4]	90% FFP Optional Expansion
Total Funds Available	$ 71,458,138	$ 30,053,529	$ 2,227,321	$ 2,227,321	$ 282,165	$ 10,402,926	$ 26,264,876
Federal Match	$ 47,878,762	$ 15,026,765	$ 1,703,901	$ 1,447,759	$ 94,133	$ 5,967,816	$ 23,638,388
Governmental Funding Entity's Portion	$ 23,579,376	$ 15,026,764	$ 523,420	$ 779,562	$ 188,032	$ 4,435,110	$ 2,626,488
	33.0%	50.0%	23.5%	35.0%	66.6%	42.6%	10.0%

Rate Categories [1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage [2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	1,126,338	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 7,614,045
Child - MCHIP 7/2020 - 9/2020	300,973	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,034,577
Child - MCHIP 10/2020 - 12/2020	300,973	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,034,577
Adult - non MCHIP	493,892	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 9,779,062
Adult - MCHIP 7/2020 - 9/2020	9,596	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 190,001
Adult - MCHIP 10/2020 - 12/2020	9,596	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 190,001
SPD	224,524	$ 814.48	$ 859.81	$ 45.33	$ -	$ 45.33	$ 10,177,673
SPD/Full-Dual	12,241	$ 205.34	$ 215.02	$ 9.68	$ -	$ 9.68	$ 118,493
BCCTP	3,493	$ 1,430.69	$ 1,511.47	$ 80.78	$ -	$ 80.78	$ 282,165
LTC	7,757	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,364,256
LTC - MCHIP 7/2020 - 9/2020	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC - MCHIP 10/2020 - 12/2020	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC/Full-Dual	0	$ 6,630.57	$ 6,780.31	$ 149.74	$ -	$ 149.74	$ -
WCM	72,916	$ 1,876.85	$ 2,019.52	$ 142.67	$ -	$ 142.67	$ 10,402,926
Optional Expansion	1,388,207	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,264,876
	3,950,524	$ 334.30	$ 354.61	$ 20.31	$ 2.22	$ 18.09	$ 71,458,138

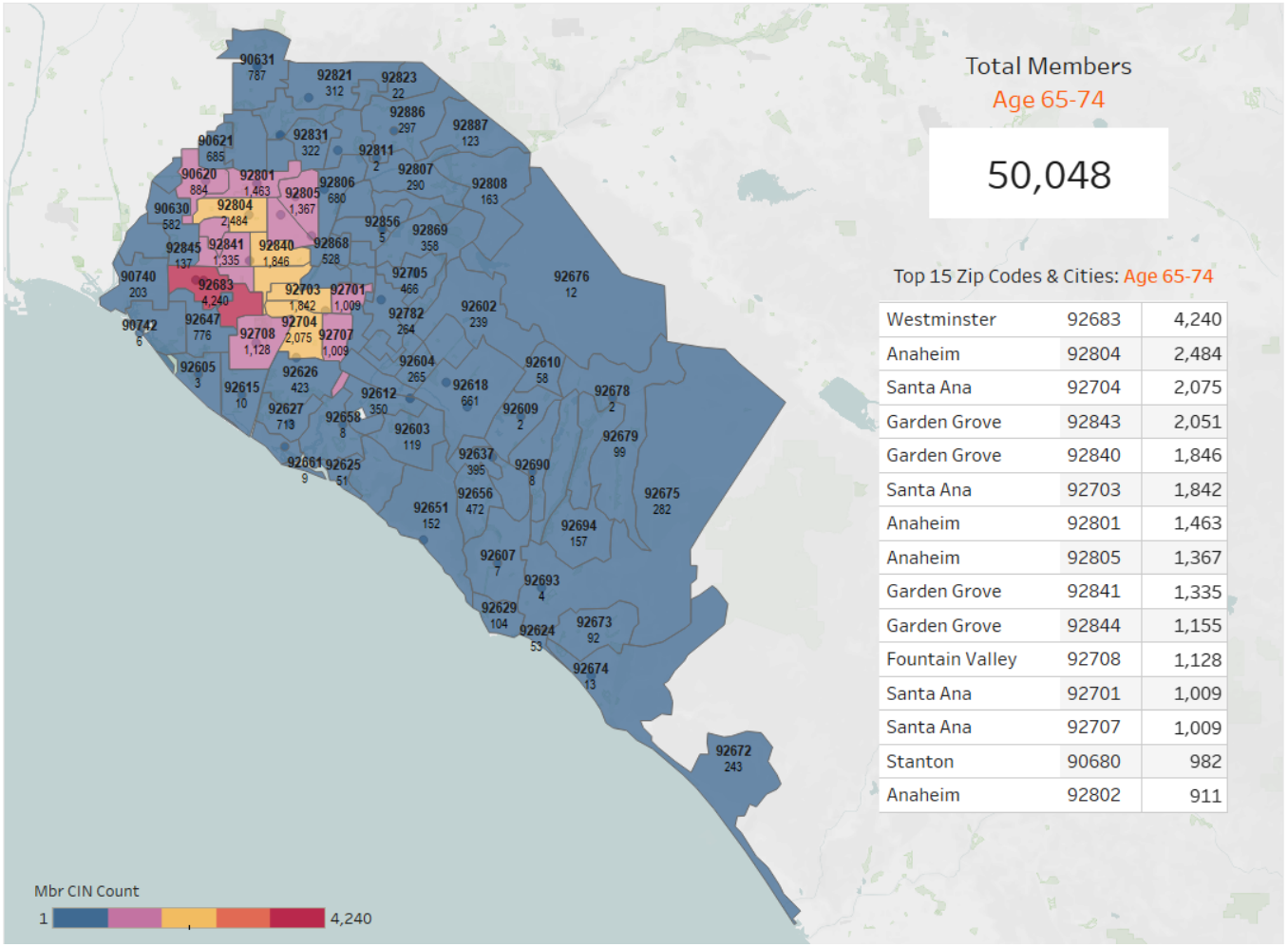
[1] The supplemental payments (Maternity, BHT and HEP C) and CCI population are not included in the rate range calculation.

[2] Other Departmental Usages decreases available rate range funding.

[3] BCCTP Federal Match is based on the portion of the population enrolleed in a BCCTP aid code associated with a FFP percentage of 65%.

[4] WCM Federal Match is based on the FFP percentage associated with the aid codes within each rating categories.

Members Ages 65-74 by City and Top Zip Codes



Data pulled on 12.29.20 Data Source: EA_MemberCurrentMonth; Time Frame: December 2020; Line of Business: All

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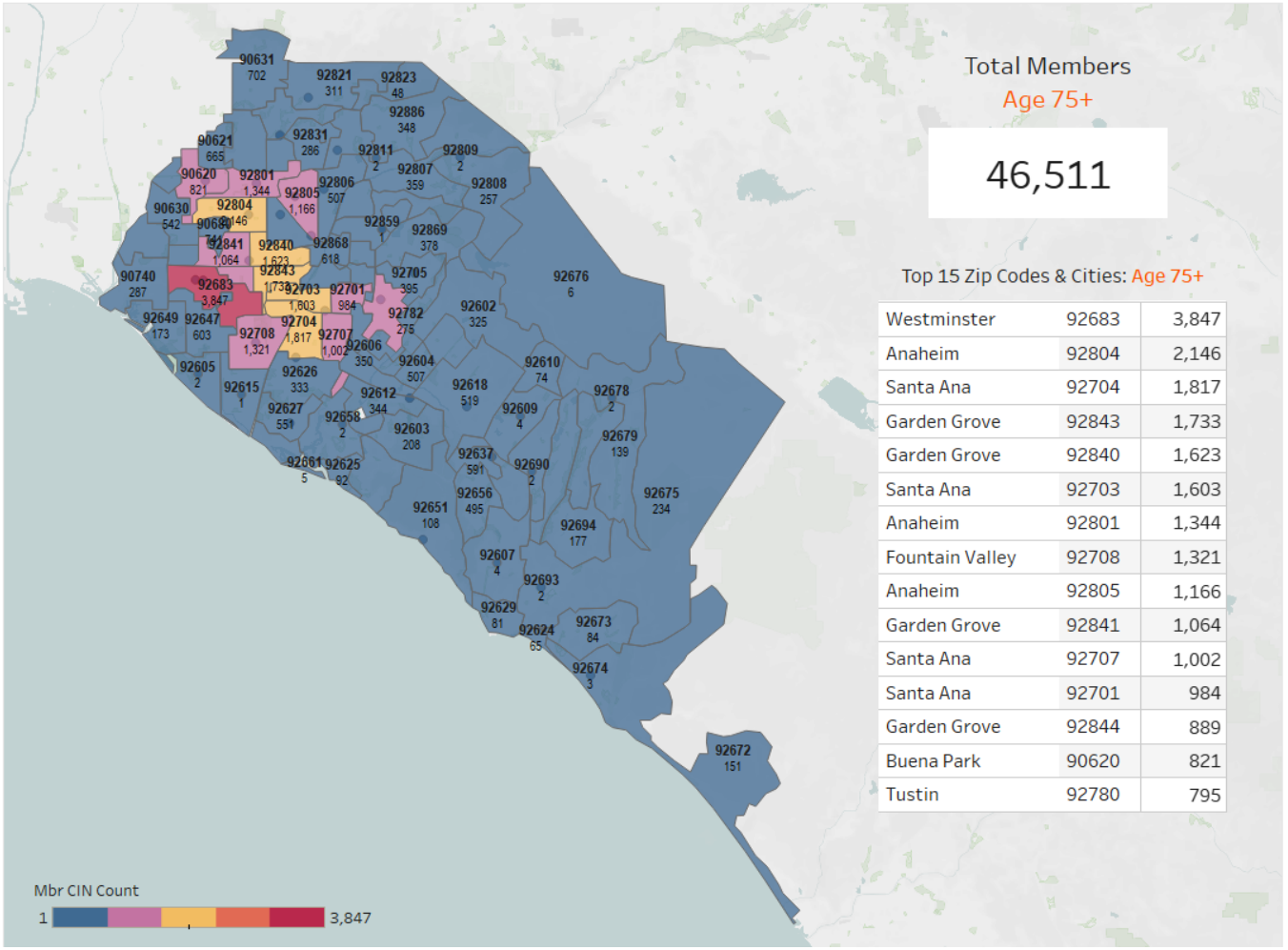
CalOptima A Public Agency

Members Age 75+ by City and Top Zip Codes



Westminster	92683	3,847
Anaheim	92804	2,146
Santa Ana	92704	1,817
Garden Grove	92843	1,733
Garden Grove	92840	1,623
Santa Ana	92703	1,603
Anaheim	92801	1,344
Fountain Valley	92708	1,321
Anaheim	92805	1,166
Garden Grove	92841	1,064
Santa Ana	92707	1,002
Santa Ana	92701	984
Garden Grove	92844	889
Buena Park	90620	821
Tustin	92780	795

Data pulled on 12.29.20 Data Source: EA_MemberCurrentMonth; Time Frame: December 2020; Line of Business: All

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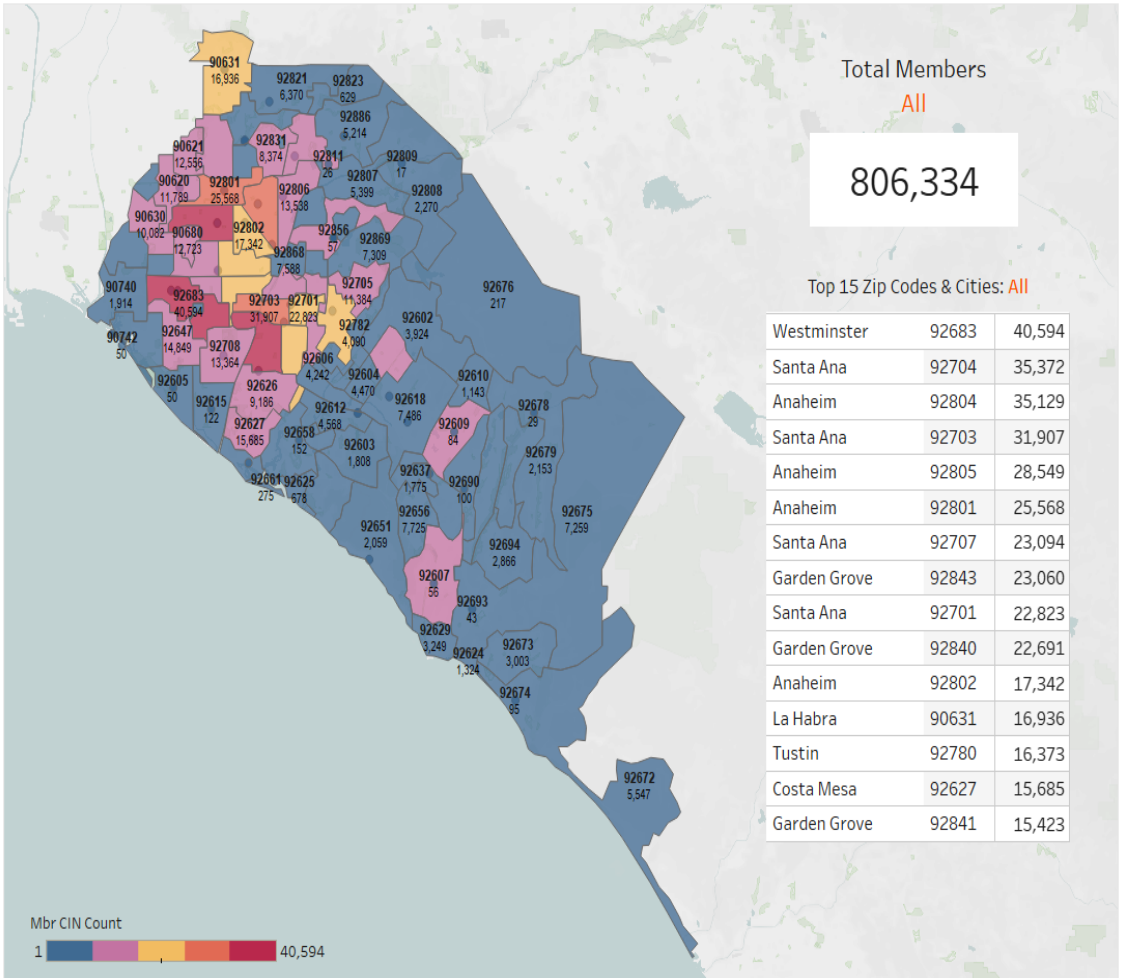
CalOptima A Public Agency

Recommendation for Targeted Vaccine Events

- Anaheim
- Garden Grove
- Santa Ana
- Westminster



Data pulled on 12.29.20 Data Source: EA_MemberCurrentMonth; Time Frame: December 2020; Line of Business: All

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Refer to Appendices for more detailed maps

CalOptima A Public Agency

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

19. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers for Mitigation of COVID-19-Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted CalOptima Medi-Cal Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Primary Care, Specialist, Behavioral Health and Ancillary Providers for certain medically necessary services provided on dates of service January 1, 2021, through June 30, 2021; and

2. Authorize unbudgeted expenditures of approximately $5.1 million to provide funding for the supplemental payment increase to Medi-Cal FFS providers.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under Section 319 of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic, and the strain it has placed on providers, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS providers is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for certain services provided during the period of January 1, 2021, through June 30, 2021. The increase is intended to support CalOptima's Medi-Cal FFS providers and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment. In some cases, groups and/or categories of services/providers not included here have separately received COVID-19-related increases based on direction from the Department of Health Care Services (e.g., long

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term care providers), prior CalOptima Board action (health networks), or staff recommendations for other actions on today's Board agenda (e.g., hospitals and community health centers). Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment increase.

Pending Board approval, the supplemental payment increase will be administered to eligible providers for identified services through the claims payment system. Staff will give notice to the providers covered by this recommended action of the 5% increase. Staff proposes making supplemental payment increases beginning in February 2021. Adjudicated and paid claims between January 1, 2021, and the processing date (a February date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment. Staff plans to identify and process the supplemental payments at the claim line level that, at a minimum, identifies the eligible date of service, service code and payment. CalOptima staff anticipates that supplemental payments will be issued to eligible providers monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. Staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Primary Care, Specialist, Behavioral Health and Ancillary Providers is an unbudgeted item. The projected aggregate fiscal impact is approximately $5.1 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS providers is intended to ensure the viability of certain CalOptima's FFS Medi-Cal providers, strengthens access to member care and supports the safety net system serving CalOptima members during the pandemic.

Concurrence

Gary Crockett, Chief Counsel

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Attachment

1. Services excluded from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

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List of Exclusions from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care services
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

20. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Hospitals for Mitigation of COVID-19 Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive, Director Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant contracted CalOptima Community Network (CCN) and CalOptima Direct (COD) Medi-Cal Fee-for-Service (FFS) Hospitals for certain medically necessary services provided on dates of service January 1, 2021 through June 30, 2021;

2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend contracts with Long Term Acute Care Hospitals (LTAC) to increase compensation for authorized inpatient services provided to CalOptima Members at the Chronic/Maintenance Level of Care for Members admitted on or after January 1, 2021, and through June 30, 2021, to offset the impacts of the COVID-19 Public Health Emergency (PHE). The increased compensation will apply to authorized dates of service between January 1, 2021, and June 30, 2021; and

3. Authorize unbudgeted expenditures up to $5.0 million to provide funding for the supplemental payment increase to Medi-Cal FFS hospitals.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under Section 319 of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

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Discussion

In recognition of the unprecedented and dynamic nature of the pandemic and the strain it has placed on hospitals, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS hospitals is recommended. CalOptima's recommends that the Board approve a supplemental payment increase for contracted Medi-Cal FFS hospitals on qualifying claims during the period of January 1, 2021, through June 30, 2021. This increase is intended to support CalOptima's contracted hospitals for covered services, for a limited period. The increase is intended to support CalOptima's Medi-Cal FFS hospitals and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment.

This item applies solely to CalOptima's contracted hospitals, including LTAC hospitals, which play a key role in treating members infected with COVID-19, and preventing the spread of COVID-19 throughout the community. Long Term Acute Care Hospitals are acute care hospitals designed for patients requiring inpatient care for an extended period of time. Admitting access to LTAC hospitals has been a key concern for members who require longer term hospital care. CalOptima's reimbursement for LTAC services falls into two levels of care: "LTAC," for which CalOptima pays a higher acute level reimbursement rate, and "chronic maintenance," a level of care that is reimbursed at a lower rate. To ensure member access to LTACs during this public health emergency, staff recommends amending contracts with LTAC hospitals to increase compensation for authorized Medi-Cal inpatient services provided to CalOptima Members at the Chronic/Maintenance Level of Care for Members admitted on or after January 1, 2021, and through June 30, 2021, to offset the impacts of the COVID-19 PHE. The increased compensation will apply to authorized dates of service between January 1, 2021, and June 30, 2021. This will be in addition to the 5% supplemental payment increase, for all authorized services for members in these facilities. Contractual billing and authorization requirements will remain in place; however, the LTAC reimbursement rate will be applied during this temporary period. Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment Increase.

Pending Board approval, the 5% supplemental payment increase will be administered to eligible hospitals for identified services through the claims payment system. Staff will provide notice to the providers covered by this recommended action of the 5% increase. Staff proposes making supplemental payment increases beginning in February 2021. Adjudicated and paid claims for dates of service between January 1, 2021, and the supplemental payment processing date (a February date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment, on a rolling time schedule. Staff plans to identify and process the supplemental payment at the claim line level that, at a minimum, identify the eligible date of service, covered billing service code and payment. CalOptima staff anticipates that supplemental payments will be issued to eligible hospitals monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims,

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timely payment requirements, such as interest, will not be applied. However, staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Hospitals is an unbudgeted item. The projected aggregate fiscal impact is approximately $5.0 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment is intended to ensure the viability of CalOptima's FFS Medi-Cal contracted hospitals, strengthens access for member care and supports the Orange County's hospital care delivery system serving CalOptima members during the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. List of Exclusions from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

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List of Exclusions from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care services
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

21. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for Mitigation of COVID-19-Related Expenses

Contact

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted CalOptima Medi-Cal Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Community Health Centers, for certain medically necessary services provided on dates of service January 1, 2021, through June 30, 2021; and

2. Authorize unbudgeted expenditures up to $210,000 to provide funding for the supplemental payment increase to Medi-Cal FFS Community Health Centers.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under Section 319 of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic and the strain it has placed on providers, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for services provided by CCN and COD-A Medi-Cal FFS Community Health Centers during the period of January 1, 2021 through June 30, 2021. The increase is intended to support CalOptima's FFS Medi-Cal providers and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment.

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This item applies solely to CalOptima's Community Health Centers—including Federally Qualified Health Centers (FQHC), FQHC look alike clinics, and community clinics—which are an important part of the safety net serving CalOptima members. They provide increased access to care for CalOptima's various member populations, including the homeless, by reducing barriers such as language, distance, and wait time. In addition to the variety of primary, preventive, and health education services they provide, Community Health Centers have a direct impact in preventing the spread of COVID-19 throughout the community by providing COVID-19 testing and treatment. Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment Increase.

Pending Board approval, the supplemental payment increase will be administered to eligible providers for identified services through the claims payment system. Staff will give notice to contracted CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers of the 5% increase following Board approval. Staff proposes making supplemental payment increases for dates of service beginning January 1, 2021 in February 2021. Adjudicated and paid claims for dates of service January 1, 2021, up until the supplemental payment processing date (a February date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment, on a rolling time schedule. Staff plans to identify and process the supplemental payment at the covered service claim line level that, at a minimum, identifies the eligible date of service, covered billing service code and payment amount. CalOptima staff anticipates that supplemental payments will be issued to eligible providers monthly from prior month's payment by the end of each month. Supplemental payments on identified eligible claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. However, staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is an unbudgeted item. The projected aggregate fiscal impact is approximately $210,000 for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is intended to ensure the viability of CalOptima's FFS Medi-

Cal clinic providers, strengthens access to member care and supports the safety net system serving CalOptima members during the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. List of Exclusions for Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

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List of Exclusions from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care services
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

22. Consider Reallocation of Intergovernmental Transfer (IGT) 9 Funds Allocated for Virtual Urgent Care (eVisit) to Support both eVisit and eConsult Implementation During Coronavirus (COVID-19) Pandemic and Beyond

Contacts

Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, (714) 246-8887
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8574

Recommended Action

Reallocate $2 million in Intergovernmental Transfer (IGT) 9 funds previously allocated for the virtual urgent care (eVisit) project to support both the eVisit and eConsult projects for CalOptima Direct, including CalOptima Community Network (COD/CCN) members and providers, during and after the COVID-19 pandemic.

Background

At its October 1, 2020 meeting, the CalOptima Board of Directors approved the redirection of up to $2.0 million in IGT 9 funds from the Member Access and Engagement: Expanded Office Hours Pilot to contracting with a 24/7 virtual urgent care vendor for services that will include implementation and rapid deployment support for CCN members during and after the COVID-19 pandemic. Based on this Board action, staff released a Request for Proposal (RFP) with the intent of selecting an eVisit services provider that meets COD/CCN members' medical needs and CalOptima's business requirements during the COVID-19 pandemic. The expectation is that the eVisit services vendor will offer virtual visits, including after-hour access for acute, non-emergency medical conditions and behavioral health conditions through the vendor's own provider network. eVisit interactions are between member and provider. Staff is continuing to work on this RFP process and will return to the Board in the near future to request approval to contract with a eVisit vendor (as well as for an eConsult vendor, as discussed below).

In addition to the eVisit project, another integral part of CalOptima's Virtual Care Strategy is the eConsult project, for which operating funding has not yet been fully allocated. An eConsult is an asynchronous service whereby a member's treating health care practitioner, such as a primary care provider (PCP), requests the opinion and/or treatment advice of another health care practitioner with specialty expertise to assist in the diagnosis and/or management of the member's health care needs, without having face-to-face contact with the specialist. Unlike synchronous (real-time) consultations, asynchronous service models are commonly referred to as "store and forward," where a patient's clinical information is collected and sent electronically to another site for evaluation. eConsult is an online interaction between provider and provider. The following diagram highlights the distinction between real-time (synchronous) eVisits, that are generally between a member and that member's provider, and non-real-time (asynchronous) eConsult services, which are typically between the member's primary care provider and a specialist):

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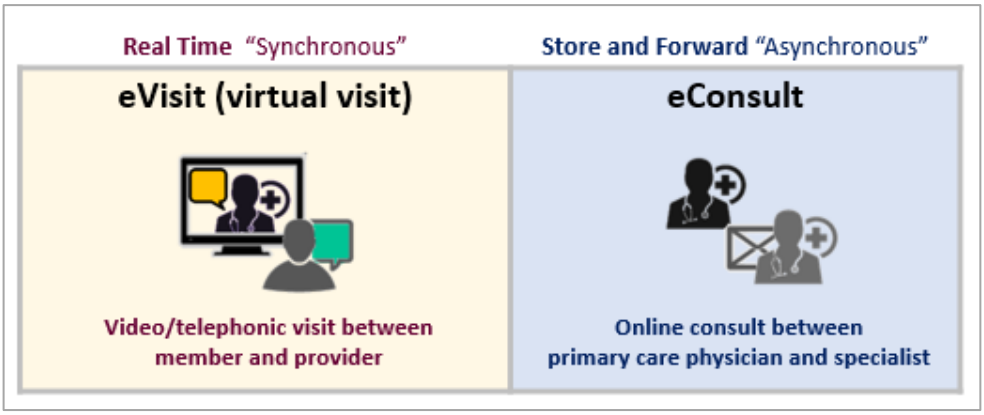

With eVisits, members have the option, when appropriate, of receiving care without going into the PCPs' offices. With eConsults, PCPs are better able to determine the best course of treatment for members with guidance from specialists and may avoid the member needing to be referred to a specialist. Moreover, should a member need to see a specialist in person, the specialist will be prepared with an enhanced referral based on eConsult information, which should help to ensure that the visit effectively meets the member's needs. Overall, eConsults support higher-value in-person visits, streamlined communication between PCPs and specialists, shorter wait times for members, and prioritization of members in need of more timely or intensive specialist services.

While conducting Request for Information (RFI) and RFP processes for the eVisit and eConsult projects, staff determined that the cost to implement the eConsult project will be significantly more than the $350,000 included for Telehealth in the CalOptima Fiscal Year 2019-20 Capital Budget. To date, there is approximately $250,000 remaining for this capital project. Fortunately, the implementation cost for the eVisit project is projected to be less costly. Therefore, staff anticipate that the $2 million in IGT 9 funds allocated at the October 1, 2020 Board meeting for a 24/7 virtual urgent care vendor for services will be sufficient to support both the eVisit and the eConsult projects. Please see the outline below of how RFI and RFP processes are being conducted for these projects:

eVisit:

- Staff completed the RFI process during Q4 of 2020 and received three (3) bidder responses.
- RFI responses were used to finalize scope of work. Through RFI, staff learned that implementation fees for eVisit would be approximately $200,000.
- Staff released the RFP in December 2020; staff expect to receive proposals by the end of January 2021.

eConsult:

- Staff released the RFP during Q3 of 2020 and received four (4) proposals
- After internal workgroup evaluations, staff narrowed down to two vendors; however, through RFP, staff also learned that implementation fees for eConsult are significantly more expensive than anticipated due to these bidders' requiring of annual licensing fees (licensing fees cost approximately $600,000). The initial eConsult budget was established for Fiscal Year 2019-20. The budget amount included $350,000 of capital budget only for implementation. Operating

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expenses were to be budgeted after year 1. The budget estimate was originally developed in 2019 before receiving the information available today. Since then project scope has greatly increased due to COVID-19 and current circumstances, thus resulting increased costs.

- To gain a better understanding of the provider experience with eConsult and assist in implementing this initiative, provider survey was sent out November 2020; staff received 30 provider responses.
- Staff performed data analysis and refined project scope in order for these bidders to submit new pricing proposals.
- Since the current budget does not cover project implementation costs, staff aims to repurpose some of the eVisit's IGT 9 funds to support this initiative.

Discussion

As the COVID-19 pandemic continues to threaten the lives of many CalOptima members, staff anticipates that both the eVisit and eConsult services will provide alternate and/or additional access to care for COD/CCN members during this challenging time.

Currently, staff estimate implementation costs for the eVisit project to be less than $200,000, based on the RFI responses. This leaves $1.8 million in IGT 9 funds available for other purposes. Therefore, staff propose expanding the approved use of the $2 million in IGT 9 funds to support the eConsult project as well, consistent with CalOptima's overarching Virtual Care Strategy. With this authorization to expand the use of the funds, CalOptima staff would refine the project scope so bidders can submit new pricing proposals. This would also allow the eConsult project to be implemented more quickly. Staff note that RFI was not conducted for the eConsult project due to the tight project implementation timeframe. However, after learning that today's market is different than what staff had anticipated, as lessons learned, the internal workgroup decided to conduct both RFI and RFP for the eVisit project to better align with project scope and budget planning. Staff will return to the Board to seek approval to contract with the recommended eVisit and eConsult vendors identified through the RFP processes.

Staff also note that with the IGT 9 funding, CalOptima aims to initiate these two projects and pay for the first year's implementation and training fees. Staff plan to launch these projects as pilots with CCN populations, and will evaluate the effectiveness of these programs in helping members meet their medical and/or behavioral needs. Upon completion of the evaluation, staff will return to the Board to request authorization to continue these programs and request appropriate funding.

In addition, providers using eConsult services will be required to submit an electronic claim for services rendered. The eConsult engagement will be a required step for providers to complete as part of the authorization request process. The future goal would be that through the eConsult services, members can avoid unneeded specialist visits, thus improving access and availability to specialist providers.

As discussed at prior CalOptima Board meetings, IGT 9 dollars are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from the Department of Health Care Services (DHCS). To the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the dollars would be charged to CalOptima's administrative loss ratio (ALR) rather than medical loss ratio (MLR). The recommendation to allow Board-allocated

IGT 9 funds to support both eVisit and eConsult implementation is consistent with the purpose of the IGT 9 funds to cover medically necessary Medi-Cal services or qualifying quality initiatives.

Fiscal Impact

The recommended action to approve reallocation of $2 million in IGT 9 funds previously allocated for the eVisit project to support both eVisit and eConsult projects for COD/CCN members and providers has no net fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Expenditure of IGT funds is for restricted, one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

The recommended action is consistent with the original aim for IGT 9 to improve Member Access and Engagement and will enable CalOptima to provide increased access to quality care for COD/CCN members during and after the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Board Action dated May 7, 2020, Consider Authorizing Virtual Care Strategy and Roadmap as Part of Coronavirus Disease (COVID-19) Mitigation Activities and Contract with Mobile Health Interactive Text Messaging Services Vendor
3. Board Action dated October 1, 2020, Consider Approval to Redirect Intergovernmental Transfer (IGT) 9 Funds Allocated for Expanded Office Hours to Support Virtual Urgent Care Implementation During Coronavirus (COVID-19) Pandemic and Beyond

/s/ Richard Sanchez — *01/27/2021*

Authorized Signature — **Date**

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Attachment to the February 4, 2021 Board of Directors Meeting – Agenda Item 22

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
RubiconMD, Inc.	214 Forest Avenue	New Rochelle	NY	10804
Safety Net Connect Inc.	4600 Campus Drive, Suite 101	Newport Beach	CA	92660
Teladoc Health, Inc.	2 Manhattanville Rd.	Purchase	NY	10577
SteadyMD Headquarters SteadyMD Los Angeles	4625 Lindell Blvd, Suite 224 2629 Townsgate Rd, Suite 130	St. Louis Westlake Village	MO CA	63108 91361
CirrusMD	3513 Brighton Blvd., Suite 230	Denver	CO	80216

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Virtual Care Strategy and Roadmap as Part of Coronavirus Disease (COVID-19) Mitigation Activities and Contract with Mobile Health Interactive Text Messaging Services Vendor

Contact

David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions

1. Approve Virtual Care Strategy and Roadmap;
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to contract with vendor mPulse Mobile, a Mobile Health Interactive Text Messaging Services vendor; and
3. Approve the recommended allocation of intergovernmental transfer (IGT) 9 funds not to exceed $3.9 million for a three-year period to provide a text messaging solution for all CalOptima member communications.

Background

As the Coronavirus Disease (COVID-19) continues to spread and threatens lives of many vulnerable populations, the COVID-19 pandemic has created an urgency for CalOptima and other Managed Care Plans (MCPs) to expand their virtual care strategy immediately to ensure timely access to care for our members and support our providers' use of virtual care during the strict social distancing measures while providers experience shortages of Personal Protective Equipment (PPE).

As a result of the COVID-19 pandemic, the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements.

At its April 2, 2020 meeting, the CalOptima Board of Directors ratified various COVID-19 mitigation activities. In addition to the approval of Telehealth Policies and Procedures to include temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements in the event of a health-related national emergency, the Board authorized contracting with Virtual Care Consultant Sajid Ahmed of WISE Healthcare to help expedite the deployment of the CalOptima Virtual Care Strategy and Roadmap.

At the same meeting, the Board approved the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives within four focus areas: member access and engagement, quality performance, data exchange and support and other priority areas. At that time, the Board approved five initiatives totaling $40.5 million. Staff would return to the Board with recommendations for allocating the remaining $4.5 million towards member access and engagement.

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Discussion

In addition to the actions approved in response to COVID-19 to date, management recommends that the Board authorize the implementation of virtual care services for members and providers with long term implications beyond the COVID-19 pandemic.

Virtual Care Strategy and Roadmap

As the sophistication and simplification of mobile technology has evolved over time beyond telehealth, virtual care is a broad definition encompassing any modality of remote technologically driven patient health care delivery, device use, monitoring, and treatment. CalOptima staff cites to an adopted virtual care definition as "any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care." [1]

CalOptima management plans to continue to use the term "telehealth" to include member materials approved by DHCS in order to be consistent with DHCS All Plan Letter (APL) 19-009: Telehealth Services Policy.

CalOptima's main Virtual Care Strategies include the following elements. Staff will return to the Board to seek authority for approval of implementation of the Virtual Care Strategies through specific vendors and initiatives in the future:

1. Support CalOptima's contracted providers' use of virtual visits during COVID-19 and beyond [all members]
    a. Technical assistance and operational support
    b. CalOptima virtual care team
    c. HIPAA compliant platform(s)
2. Contract with specialty providers with a virtual care focus for CCN members.
    a. Provider(s)/vendor(s) to treat chronic pain/opioid dependency, and provide medication assisted treatment, and eating disorder treatment
    b. Other specialties as available
3. Contract with a vendor offering virtual visits including after-hour access for all CalOptima members regardless of network assignment for acute non-emergency medical conditions and behavioral health conditions through its own provider network
    a. Integrate with CalOptima website and/or member portal
    b. Technical support for members
    c. Integrate with existing nurse advice line
    d. Develop member smartphone app
4. Contract with a vendor offering eConsults for CCN members and PCP's through CalOptima contracted specialists who wish to participate and/or its own provider network
    a. Technical assistance and operational support for CCN providers
    b. Integrate with CCN UM process
    c. Integrate with CCN provider portal
5. Member texting
    a. Via CalOptima member smartphone app

With these proposed Virtual Care Strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits:

- Improved member access and convenience;
- Reduced avoidable in person visits to specialists; and
- Decreased wait time for specialty visits by members.

CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care:

- Improved member experience;
- Augmented network capacity and adequacy; and
- Improved clinical quality outcomes.

As recommended by staff, CalOptima's Virtual Care Strategy proposes a detailed logic model and a work plan which are included in the attachments (refer to Attachment 3 and Attachment 4).

Proposal to Implement Mobile Health Interactive Text Messaging Services

CalOptima currently uses traditional modes of member communication, including telephonic, print and mail. CalOptima staff seeks to strengthen communication outreach opportunities to our members through Mobile Health Interactive Text Messaging Services that will:

- Deliver useful health promotion and prevention messaging;
- Promote healthy behaviors among members;
- Facilitate behavior change;
- Provide support through impactful media;
- Promote wellness and preventive care including Healthcare Effectiveness Data and Information Set (HEDIS) measures;
- Improve clinical outcomes; and
- Encourage adherence to recommended care practices

CalOptima's RFP minimum requirements for the mobile texting vendor include the following:

- Provide Mobile Text Messaging services to enhance member engagement by supporting CalOptima in implementing a secure communication program designed to close gaps in care, improve quality scores, drive higher engagement and satisfaction for CalOptima's members.
- Deliver technology platform for managing outreach to CalOptima's members via text message. The interactive messages must operate as a reliable, secure, and high-speed messaging system of use in the health care environment.
- Ensue that content written at a sixth grade reading level or below so that the information is easy to understand.
- The Platform must be a Health Insurance Portability and Accountability Act (HIPAA) compliant platform with secure encryption texting capability to ensure the safe management of Protected Health Information (PHI) and other sensitive data.

Through a Request for Proposal (RFP) process conducted in 2019, CalOptima staff received eight (8) responses and with two finalist texting solution vendors, HealthCrowd and mPulse Mobile (mPulse). CalOptima's Mobile Texting RFP Selection workgroup is recommending that the Board authorize a

contract with mPulse based on it receiving the highest evaluation score (refer to Attachment 5) mPulse specializes in Conversational Artificial Intelligence (AI) solutions for the healthcare industry and promotes improved health outcomes by engaging individuals with tailored and meaningful dialogue. mPulse combines behavioral science, analytics and industry expertise to help healthcare organizations promote their members acquiring healthy behaviors. mPulse is HIPAA and Telephone Consumer Protection Act (TCPA)-compliant, and Health Information Trust (HITRUST) Alliance-certified.

CalOptima's Mobile Texting RFP Selection workgroup is recommending Board authorization for a contract of three years in an amount not to exceed $3,900,000. Based on the CalOptima membership, the estimated annual cost for the contract is approximately $1,000,000, with a separate expense of $80,256 for implementation and set-up. Staff recommends allocating IGT 9 funding not to exceed $3.9 million under the Board-approved focus area of Member Access and Engagement. In addition, staff recommends entering into further negotiations and pursing a contract with mPulse with the assistance of CalOptima's Procurement and Legal Departments.

As discussed at prior CalOptima Board meetings, IGT 9 dollars are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from the DHCS in that, to the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's General and Administrative categories, which are included in administrative loss ratio (ALR).

DHCS requires MCPs to submit a texting program and/or its individual texting campaign approval form to the state. DHCS will review and respond within 60 days of submission of the form (See Attachment 7).

As indicated, staff will return to the Board to seek authority for approval of other elements of the Virtual Care Strategy in the future.

Fiscal Impact

The recommended action to approve the Virtual Care Strategy and Roadmap has no additional fiscal impact for Fiscal Year (FY) 2019-20. Staff will address new virtual care strategies including a vendor offering 24/7 virtual visits and a vendor offering eConsults in future board reports and recommended actions.

The recommended action to select and contract with mPulse, a mobile health interactive text messaging services vendor has no net fiscal impact to CalOptima's operating budget over the proposed project term. Staff estimates that IGT 9 revenue from DHCS will be sufficient to cover the allocated expenditures for the initiative recommended in this report.

Rationale for Recommendation

The recommended actions are important steps in enabling CalOptima to provide additional access to quality care for our members and providers during and after the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated April 2, 2020, Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities
2. CalOptima Virtual Care Roadmap Presentation
3. Virtual Care Strategy Logic Model
4. Virtual Care Strategy Work Plan
5. 19-20 Texting RFP Final Team Evaluation Summary Scoring Criteria
6. Texting Program RFP Scope of Work
7. DHCS Texting Program & Campaign Submission Form
8. Board Action dated February 7, 2019, Consider Approval of CalOptima Population Health Management Strategy for 2019
9. Entities Covered by this Recommended Board Action

Reference
1. Shaw J, Jamieson T, Agarwal P, et al. Virtual care policy recommendations for patient-centered primary care: findings of a consensus policy dialogue using a nominal group technique. J Telemed Telecare 2018;24(9):608-15.

/s/ Richard Sanchez *04/29/2020*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

Contact

David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions

1. Ratify CalOptima Medi-Cal Policy GG.1665: Telehealth and Other Technology-Enabled Services and Medicare Policy MA.2100: Telehealth and Other Technology-Enabled Services and authorize Staff to update the COVID-19 addendums to such policies on an ongoing basis, as necessary and appropriate to align with new government waivers and guidance;
2. Ratify contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy;
3. Ratify contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and
4. Authorize reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants.

Background/Discussion

Telehealth Policies and Procedures (P&Ps)

One of CalOptima's primary strategic priorities is to expand the Plan's member-centric focus and improve member access to care by using telehealth (also known as virtual care) to fill gaps in provider networks and meet network certification requirements. CalOptima would like to improve member experience by incorporating new modalities to make it more convenient for members to access care on a timely basis. In addition to better assisting our members, we believe telehealth can increase value and improve care delivery by deploying innovative delivery models.

In addition, as the new novel coronavirus has emerged and continues to spread around the United States (COVID-19 Crisis), it has become more imminent that CalOptima needs to establish telehealth (virtual care) services as soon as possible to ensure safe access to care for our community, members and providers.

As a result of the COVID-19 Crisis, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth, APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic and CMS' telehealth guidelines, The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services curing the COVID-19 crisis.

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Medi-Cal and Medicare telehealth guidelines differ in some respects such that CalOptima has developed separate Medi-Cal and Medicare policies. These policies include addendums addressing criteria and requirements that are waived during the COVID-19 Crisis. Since government waivers and guidance are fluid, staff also seeks Board authority to update telehealth guidance on the COVID-19 crisis as necessary and appropriate.

Medi-Cal Telehealth Policy

CalOptima's GG.1665: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement for Medi-Cal Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements;

- Requirements that Qualified Providers must comply with when using Telehealth to furnish Covered Services including, but not limited to Member consent, confidentiality, setting, and documentation requirements;

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

- In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

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Policy:	GG.1665
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

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D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

a. The Qualified Provider meets the following licensure requirements:

i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

b. The Member has provided verbal or written consent in accordance with this Policy;

c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

   a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

   b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

   a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

   b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

   c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

    a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

    b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeals Process
E. CalOptima Policy GG.1603: Medical Records Maintenance
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

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I. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date		Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

Policy:	MA.2100
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable

Applicable to:
- ☐ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative – External

I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.

F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

Back to Agenda Back to Item

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Members must consent to the provision of virtual Covered Services that are provided via secure electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-Visits, which consent shall be documented in the Member's medical records.

B. Provision of Covered Services through Telehealth

1. A Qualified Provider may provide Covered Services to an established Member via Telehealth when all of the following criteria are met:

   a. The Member is seen in an Originating Site;

   b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA);

   c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified Provider;

   d. The Telehealth Covered Services encounter must be provided through Interactive Audio and Video telecommunication that provides real-time communication between the Member and the Qualified Provider (store and forward is limited to certain demonstration projects). See Section III.C. of this Policy for other Technology-Enabled services that are not considered to be Telehealth, and which may be provided using other modalities; and

   e. The type of Telehealth Covered Services fall within those identified in the CMS List of Services (available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

   f. The Qualified Provider must be licensed under the state law of the state in which the Distant Site is located, and the Telehealth Covered Service must be within the Qualified Provider's scope of practice under that state's law.

2. The Originating Site for Telehealth Covered Services may be any of the following:

a. The office of a physician or practitioner;

b. A hospital (inpatient or outpatient);

c. A critical access hospital (CAH);

d. A rural health clinic (RHC);

e. A Federally Qualified Health Center (FQHC);

f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);

g. A skilled nursing facility (SNF); or

h. A community mental health center (CMHC).

3. Telehealth Service Requirements and Electronic Security

   a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.

      i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

      ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

      iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.

4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

   a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

   b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

C. Other Technology-Enabled Services

1. Virtual Check-In Services

a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In Services to connect with Members outside of the Qualified Provider's office if all of the following criteria are met:

i. The Virtual Check-In Services are initiated by the Member;

ii. The Member has an established relationship with the Qualified Provider where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available);

iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;

iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate Members on the availability of the service prior to the Member's consent to such services); and

v. The Member verbally consents to Virtual Check-In Services and the verbal consent is documented in the medical record prior to the Member using such services.

b. Live interactive audio, video or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D below.

c. Qualified Providers may bill for Virtual Check-In Services furnished through secured communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

2. E-Visits

a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a secure online patient portal if all of the following criteria are met:

i. The Member has an established relationship with a Qualified Provider;

ii. The provider furnishing the E-Visit is a Qualified Provider; and

iii. The Members generates the initial inquiry (communications can occur over a seven (7)-day period).

b. Live interactive audio, video, or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D. of this Policy.

c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable, for E-Visits.

3. E-Consults

a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone, internet and Electronic Health Record modalities are permitted where such consult services meet the requirements in applicable billing codes, including time requirements.

b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452 for E-Consults.

4. Remote Monitoring Services

a. Remote Monitoring Services are not considered Telehealth Covered Services and include Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring and Principle Care Management services.

b. Remote Monitoring Services must meet the requirements established in applicable billing codes.

D. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of the electronic transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and MA.9004: Expedited Service Appeal.

F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by this Policy shall be made in accordance with all applicable CMS requirements and guidance.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract for Health Care Services
D. CalOptima Policy CMC.9002: Member Grievance Process
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy MA.9002: Member Grievance Process
H. CalOptima Policy MA.9003: Standard Service Appeal

I. CalOptima Policy MA.9004: Expedited Service Appeal
J. Title 42 United States Code § 1395m(m)
K. Title 42 CFR §§ 410.78 and 414.65
L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS' list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

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

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.[1] This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.[2] *Revised text is found in italics.*

BACKGROUND:
The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),[3] codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,[4] Health and Safety Code (HSC) Section 1374.13,[5] and Welfare and Institutions Code (WIC) Sections 14132.72[6] and 14132.725.[7] For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

[1] The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc
[2] More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx
[3] AB 415 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415
[4] BPC Section 2290.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC
[5] HSC Section 1374.13 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC
[6] WIC Section 14132.72 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC
[7] WIC Section 14132.725 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:
Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

If you have any questions regarding this supplemental guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

[*e*] sajcookie@gmail.com [*c*] +1.415.377.9514 [*a*] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. **Data Architect**

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

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(949) 229-7684 FAX

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3/07-1/08 Primary Provider Management Company San Diego, CA
Medical Director, Family Choice Medical Group, Vantage Medical Group-San Diego

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA
Physician Consultant, Medical Services for Indigents Program

- Utilization Management
- Program Development
- Formulary Development

10/02–7/07 Community Care Health Centers Huntington Beach, CA
Associate Medical Director

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA
Clinical Instructor of Family Medicine, Department of Family and Preventive Medicine

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(949) 229-7684 FAX

EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship — Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program — San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School — Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English — East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present	California A070698
2001-Present	Diplomate, American Board of Family Practice
2014-Present	Diplomate, American Board of Addiction Medicine
2020-Present	Diplomate, American Board of Preventive Medicine, Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

E-MAIL PSCHEID12@GMAIL COM
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TANYA DANSKY, MD

PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

SKILLS/EXPERTISE

Executive Leadership
Medi-Cal and CA Commercial HMO
Quality Improvement
Utilization Management
Strategic Business Operations
Value Based Contracting
Washington State Medicaid
Population Health
Innovation
Social Determinants of Health

WORK HISTORY

Independent Consulting Feb. 2020 – Present

Clinical Advisor, Harbage Consulting

- Projects include providing clinical leadership and expertise for:
  - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
  - CalAIM Enhanced Case Management and In Lieu of Services

Blue Shield of California April 2017 – Feb. 2020

VP & Chief Medical Officer, Promise Health Plan

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

CalOptima
A Public Agency
Better. Together.

Virtual Care Strategy: Road Map to Increase Access to Care

Board of Directors Meeting

May 7, 2020

Sajid Ahmed, CEO WISE Healthcare, CalOptima Virtual Care Expert

Betsy Chang Ha, RN, MS, LSSMBB
Executive Director, Quality & Population Health Management

On Strategy

"For some organizations, near-term survival is the only agenda item.

Others are peering through the fog of uncertainty, thinking about how to position themselves once the crisis has passed and things return to normal.

Crisis

危機

A time of danger

A time of opportunity

The question is, 'What will normal look like?' While no one can say how long the crisis will last, what we find on the other side will not look like the normal of recent years."

~ Ian Davis, 2009

During the Great Recession

Agenda

- Traditional Barriers to Telehealth
  - Impact of COVID-19 on Regulations
- Virtual Care Definition (Telehealth)
- Virtual Care Modalities
- Virtual Care Roadmap Approach
  - Logic Model: Virtual Care Adoption for CalOptima
- The Future
  - Lifting of Barriers
  - Will They Stay or Will They Go Now?
- CalOptima Virtual Care Strategy

Traditional Barriers

- Payment and compensation (Provided due to COVID-19)
- Disruptive to current workflow (Yes, post COVID-19)
- Got enough on my plate (COVID-19 response is priority)
- Their convenience, not mine (COVID-19 response is priority)
- New technology, learning (Not really but in some cases)
- Laws, rules, and regulations (Relaxed due to COVID-19)
- Liability questions (Telehealth Insurance now standard)

Impact of COVID-19 on Regulations

- On March 11, 2020, the World Health Organization declared the COVID-19 outbreak a pandemic.
- On March 15, Health and Human Services issued a "limited waiver" of Health Insurance Portability and Accountability Act sanctions.
- On March 17, Centers for Medicare & Medicaid Services said it would expand Medicare coverage of telemedicine services.
  - CMS said Medicare will pay providers the same in-person rates for virtual visits with hospitals, doctors and other licensed clinicians […] regardless of the patients' location.
- And on and on ...

Virtual Care Definition

- Beyond telehealth, Virtual Care is a broad definition encompassing any modality of remote technologically driven patient health care delivery, device use, monitoring and treatment.

- A recent paper offered the following definition of virtual care:
  - Any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care.

By Shaw J, Jamieson T, Agarwal P, et al. Virtual care policy recommendations for patient-centered primary care: findings of a consensus policy dialogue using a nominal group technique. J Telemed Telecare 2018;24(9):608-15.

Virtual Care Modalities

	Real Time "Synchronous"	**Store and Forward** "Asynchronous"
Visits (Provider to Patient)	**Virtual Visit**  Video/telephonic visit between provider and patient	***e*Visit**  Online exchange (e.g., email or text) between provider and patient
Consults (Provider to Provider)	**Virtual Consult**  Video/telephonic consult between provider to patient's provider	***e*Consult**  Online consult between specialist to patient's local provider

Virtual Care **IS** care provided via phone, email, text, and video.
87% of all diagnostic decisions can be made via Virtual Care

Image courtesy of Sajid Ahmed at WISE Healthcare.

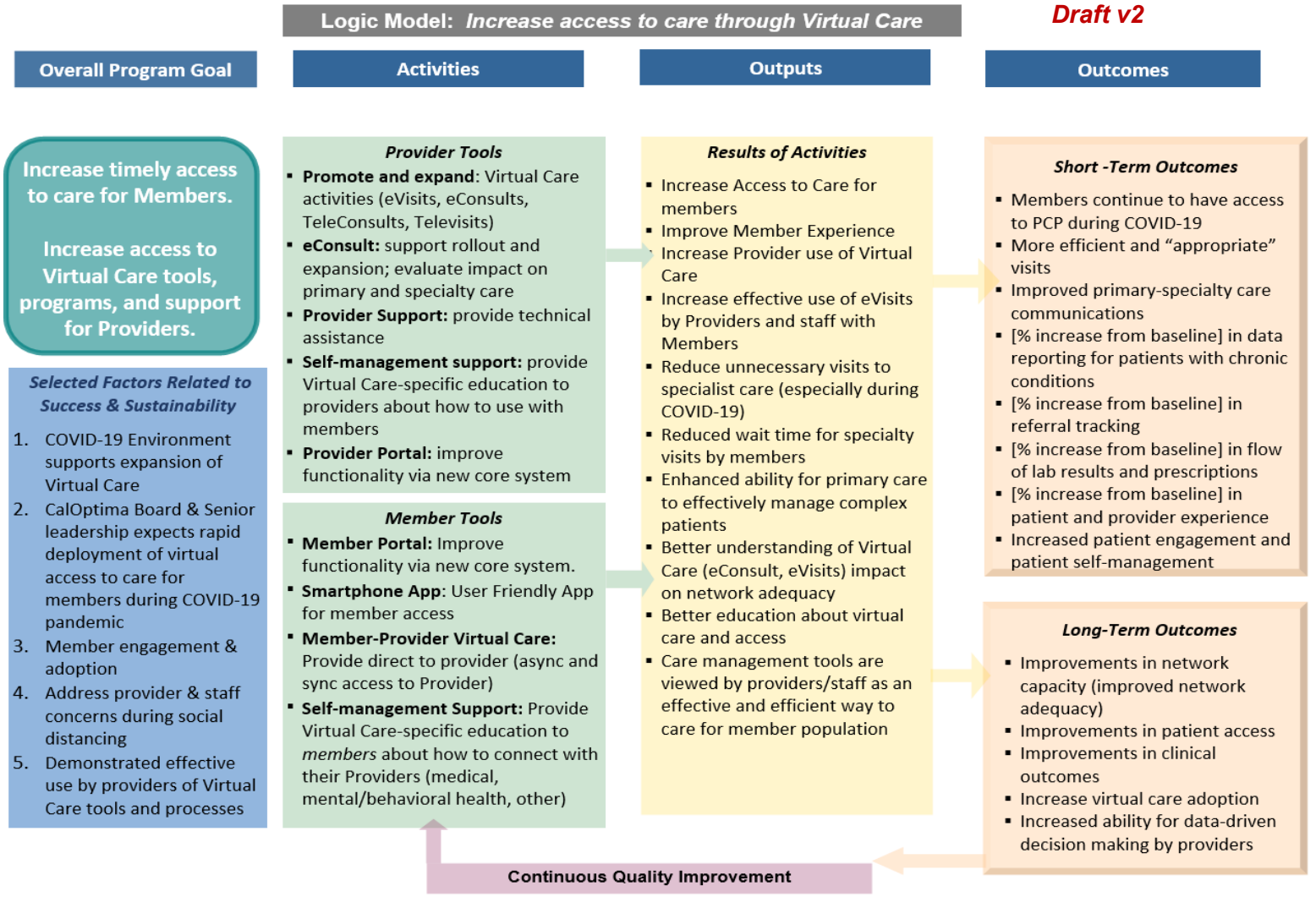
Examples of Virtual Care Modalities

	Real Time / "Synchronous"	Store and Forward / "Asynchronous"
Visits (Provider to Patient)	**Virtual Visit** (Telephone or Video Calls) BRIGHT HEART HEALTH TELADOC MDLIVE	***e*Visit** (Emails &Text Messages) text4baby mPulse mobile CAPTUREPROOF
Consults (Provider to Provider)	**Virtual Consult** • Live Case-based Learnings • Live remote monitoring eICU Program Project ECHO	***e*Consult** • Direct email via EHR • Health Information Exchanges SAFETY NET CONNECT

Examples only. CalOptima does not endorse specific vendor.

Image courtesy of Sajid Ahmed at WISE Healthcare.

Logic Model: Increase Access to Care Through Virtual Care



MCP Guidance for Use of Virtual Care by Members and Contracted Providers (cont.)

Member

- Member will use the provider-given cell number to **text** the provider with their reason to request a virtual visit (chief complaint, medical concern, follow-up visit).
- Provider and member will communicate back and forth using text messages (member to provider eConsult).
  - If member concerns are resolved at this stage, no further action is necessary.

- If the provider deems a phone **call** necessary, text messages will be used to coordinate the call.
  - With all stages of communication, the provider can use any location (home) as a responding site.

- If after the phone conversation the provider deems that a **video call** would be necessary, text messages are used to coordinate a video call.

Disclaimer: MCPs do not recommend, endorse, nor sponsor specific messaging applications nor cellular providers.

MCP Guidance for Use of Virtual Care by Members and Contracted Providers

Due to COVID-19, select federal and state virtual care restrictions have been lifted — the use of smartphones and other communication applications to facilitate dialogue between providers and members has been approved. This communication will be allowed and reimbursable per CMS and DHCS directives.

Protocol: Providers and members can text, call and video call to coordinate and manage care to and from any location (home).

Providers

Providers will select a SMS text enabled cell number that can be used by patients. If possible, this can be the provider's primary cell number or:

- An app can be used that allows the provider to receive multimedia messages (WhatsApp, iMessage, Line, GroupMe, Google Duo, Arya, etc.)
- Providers can obtain a new cell number to be used for this purpose through any cellular carrier

Providers can designate a staff member to monitor communication with this number (possibly through a group chat) and facilitate member provider coordination.

Every Cloud Has a Silver Lining...

- It took the COVID-19 pandemic to
  - Waive or relax most health care regulations to ensure that patients get the best possible care at the lowest possible cost, when and where they need it.
- The federal rules and regulations providing limited waivers due to the COVID-19 pandemic are:
  - **HIPAA sanctions waiver** — waiving patient consent
  - **Telemedicine reimbursement** — provided for all virtual care
  - **Physician scope of practice** — lets "all doctors and medical professionals to practice across state lines to meet the needs of hospitals that may arise in adjoining areas"
  - **Elective surgery guidance** — limits elective surgical and dental procedures for adults
  - **Quality reporting requirements** — suspended or extended

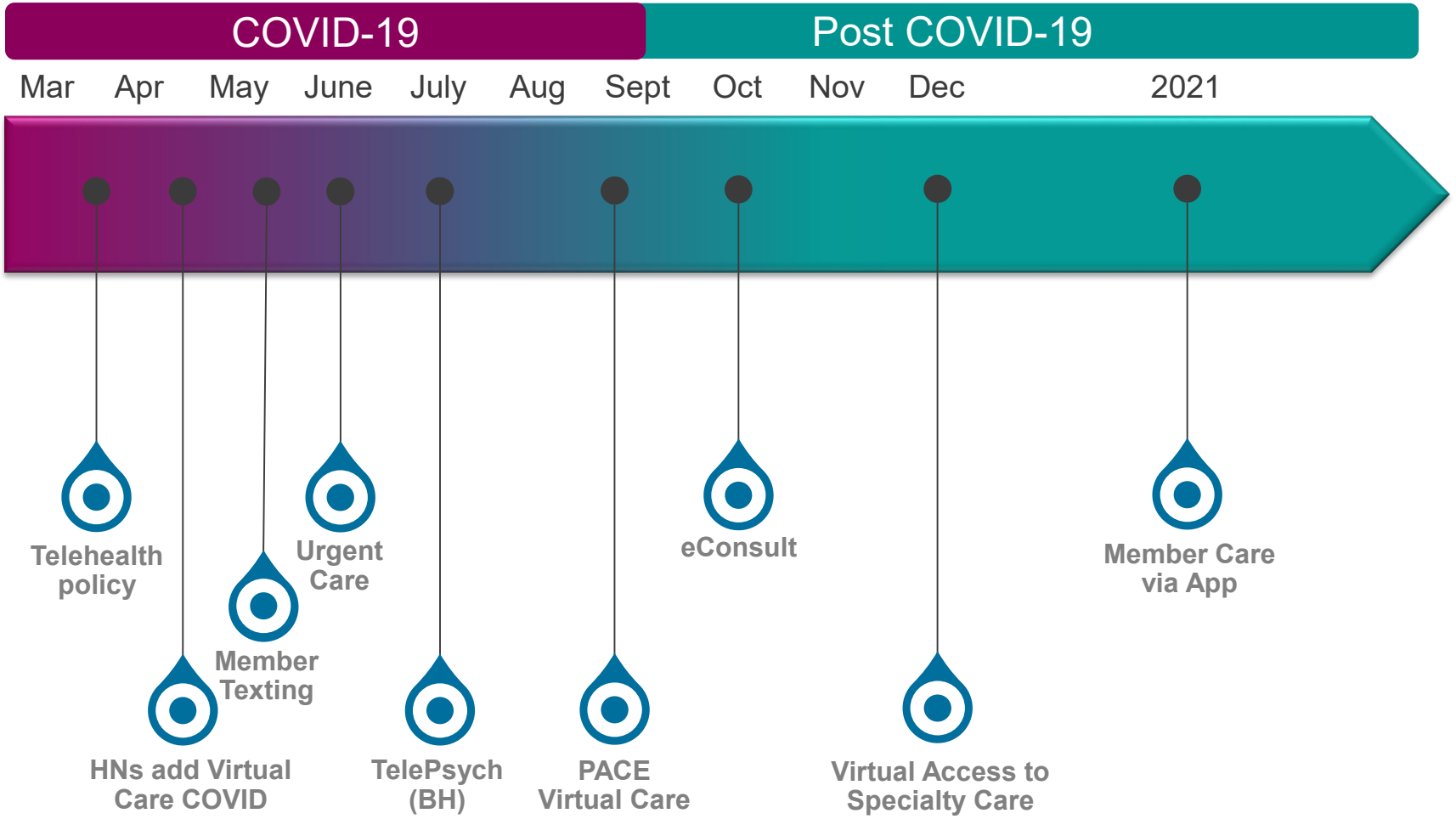
Regulations: Will They Stay, or Will They Go?

- The outbreak shined a light on all the rules and regulations that the U.S. health care system operates under.
- Regulations and rules shown to be impediments to safe, effective, convenient, accessible and affordable care for members.
- CalOptima's long term Virtual Care strategy provides a roadmap to navigate the future in providing low-cost, high quality, timely access to care.

Key Takeaways

- COVID-19 morphed virtual care into a powerful resource that enables the disruption of health care delivery.
- In-person care and virtual care are to be treated the same as appropriate. With virtual care expected to be the primary modality to access care in the future.
  - The “new normal”
- Leadership support is needed from the Board, Chiefs, physician champions, and Health Networks to achieve success and meet the challenges and opportunities of the health care “new normal”

High Level Virtual Care Roadmap



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CalOptima Virtual Care Strategy (Road Map)

Board of Directors Regular Meeting
May 7, 2020

David Ramirez, M.D., Chief Medical Officer

Betsy Chang Ha, RN, MS, LSSMBB
Executive Director, Quality & Population Health Management

Virtual Care Guiding Principles

- Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management;
- Leverage existing delivery model where possible;
- To be proactive in seeking out opportunities to innovate; and
- To provide technology-agnostic solutions.

Proposed Initial Virtual Care Strategy: All Members (HN/CCN/COD)

Member to Provider		
Goals	**Use Existing Network Providers**	**Contract Vendor(s) to support limited scope of services during COVID-19**
Tasks	• Leverage existing capabilities • Guidance • Technical support • Technology agnostic	• Member self-referral via Member Portal (web) • Urgent care • Prescription management • Access to Behavioral Health
Time	Q1 2020	Initiate Contract in Q2–Q3 2020
Action	**Update Telehealth Policy (completed)**	**RFP (IGT 9) for vendor(s)**

Proposed Initial Virtual Care Strategy: CalOptima Community Network & CalOptima Direct

	Member to Provider	Provider to Provider
Goals	**Provide Virtual Care:** Member access to Provider Group(s), eVisits to primary care and specialist services	**Implement eConsult (CCN)** (Provider to Provider) per DHCS APL 19-009 to provide eConsult as a covered benefit
Tasks	• Support existing physical primary care providers and specialists • Behavioral Health Services (for all members) • Expand specialty providers with a virtual care focus	• Prior Authorization process modified to allow eConsult to replace authorization • Make available to PACE as well • Provider self-service and submit authorization via Provider Portal and eConsult
Time	Selection in Q3 2020	Contract in Q4 2020
Action	**Evaluate telehealth providers/groups**	**Develop plan to implement eConsult**

Virtual Care Roadmap Q2–Q4

High Level Activities

1. Member engagement approaches, app support and tools
2. Continue activities to support COVID-19 related items
3. Virtual Care technical platform for PACE
   - Facilitate provider-member virtual visits
4. Investigate and implement provider support and technical assistance
5. In progress:
   - Virtual Care Strategy and Roadmap
   - CalOptima Virtual Care Team
6. Expand specialty providers with a virtual care focus
   - Behavioral health and other specialties

Virtual Care Roadmap Q2–Q4 (cont.)

High Level Activities (cont.)

7. Offer 24/7 virtual visits (after-hour access)
   - Acute non-emergency medical conditions
   - Behavioral health conditions
8. Investigate and implement CalOptima member engagement access via member portal app
   - APIs to virtual visits, eVisits, secure messaging
9. Plan and launch eConsult/eReferral program for CCN
10. Member texting
    - E.g. Text For Baby, notifications, alerts via CalOptima Smart app, e.g. IEHP Smart Care app
11. RFP for member direct to provider access
    - Member to provider


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Medi-Cal
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OneCare (HMO SNP)
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OneCare Connect
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PACE
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Logic Model: *Increase access to care through Virtual Care*

Draft v2

Overall Program Goal	Activities	Outputs	Outcomes

Increase timely access to care for Members.

Increase access to Virtual Care tools, programs, and support for Providers.

Selected Factors Related to Success & Sustainability

1. COVID-19 Environment supports expansion of Virtual Care
2. CalOptima Board & Senior leadership expects rapid deployment of virtual access to care for members during COVID-19 pandemic
3. Member engagement & adoption
4. Address provider & staff concerns during social distancing
5. Demonstrated effective use by providers of Virtual Care tools and processes

Provider Tools

- **Promote and expand**: Virtual Care activities (eVisits, eConsults, TeleConsults, Televisits)
- **eConsult:** support rollout and expansion; evaluate impact on primary and specialty care
- **Provider Support:** provide technical assistance
- **Self-management support:** provide Virtual Care-specific education to providers about how to use with members
- **Provider Portal:** improve functionality via new core system

Member Tools

- **Member Portal:** Improve functionality via new core system.
- **Smartphone App**: User Friendly App for member access
- **Member-Provider Virtual Care:** Provide direct to provider (async and sync access to Provider)
- **Self-management Support:** Provide Virtual Care-specific education to *members* about how to connect with their Providers (medical, mental/behavioral health, other)

Results of Activities

- Increase Access to Care for members
- Improve Member Experience
- Increase Provider use of Virtual Care
- Increase effective use of eVisits by Providers and staff with Members
- Reduce unnecessary visits to specialist care (especially during COVID-19)
- Reduced wait time for specialty visits by members
- Enhanced ability for primary care to effectively manage complex patients
- Better understanding of Virtual Care (eConsult, eVisits) impact on network adequacy
- Better education about virtual care and access
- Care management tools are viewed by providers/staff as an effective and efficient way to care for member population

Short -Term Outcomes

- Members continue to have access to PCP during COVID-19
- More efficient and "appropriate" visits
- Improved primary-specialty care communications
- [% increase from baseline] in data reporting for patients with chronic conditions
- [% increase from baseline] in referral tracking
- [% increase from baseline] in flow of lab results and prescriptions
- [% increase from baseline] in patient and provider experience
- Increased patient engagement and patient self-management

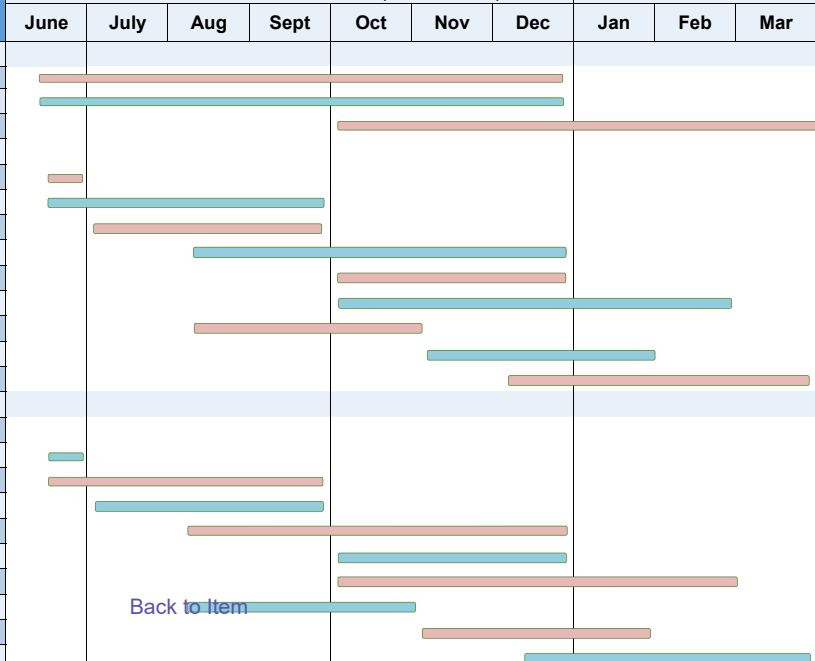
Long-Term Outcomes

- Improvements in network capacity (improved network adequacy)
- Improvements in patient access
- Improvements in clinical outcomes
- Increase virtual care adoption
- Increased ability for data-driven decision making by providers

Continuous Quality Improvement

Cal Optima Virtual Care High Level Workplan

2020 - Phase IIA - Foundation (New Fiscal)



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TEAM SUMMARY SCORES

RFP 19-020 – Mobile Text Messaging Services

Proposals Scores

Vendor Name	Score
mPulse	3.57
HealthCrowd	3.45
Bluespire	3.63
TigerConnect	3.32
Medecision	3.19
MTX Group Inc.	3.17
Variedy	3.10
Care3	3.04

Interview Scores

Vendor Name	Score
mPulse	4.30
HealthCrowd	4.18
Bluespire	3.73
TigerConnect	2.51
Medecision	0.00
MTX Group Inc.	0.00
Variedy	0.00
Care3	0.00

Overall Scores

Vendor Name	Score
mPulse	3.94
HealthCrowd	3.81
Bluespire	3.68
TigerConnect	2.92
Medecision	3.19
MTX Group Inc.	3.17
Variedy	3.10
Care3	3.04

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M E M O R A N D U M

DATE: May 22, 2019

TO: Pshyra Jones, Ashley Young, Kelly Rex-Kimmet, Belinda Abeyta, Albert Cardenas, Erica Neal, Christine Sisil, Adriana Ramos, Edwin Poon, Diane Ramos, Lisa Ha

FROM: Maria Medina, CPPB

SUBJECT: RFP 19-020 – Mobile Text Messaging Services

EVALUATION PROCESS INSTRUCTIONS:

IMPORTANT….If you are contacted by any vendor regarding this RFP process, please do not speak with this vendor and forward all calls to my attention.

Step One: ***Review all Proposals***. Evaluation committee members were provided with copies of each RFP response to begin their individual review of the Proposals. **Take notes, make comments and/or prepare questions for discussion.** Do not score at this point.

Step Two: ***Determine status***. Make an initial determination as to whether each Proposal is "responsive" or "non-responsive." A "responsive" proposal conforms in all material respects to the RFP. A proposal may be deemed "non-responsive" if essential required information is not provided, the submitted price is found to be excessive or inadequate as measured by criteria stated in the RFP, or the proposal is clearly not within the scope of the project described and required in the RFP. *Extreme care should be used when making this decision because of the time and cost that a vendor has put into submitting a proposal. If a proposal is determined to be "non-responsive," it will not be considered further. The Purchasing department will make the final determination of responsiveness. If a determination of "non-responsiveness" is made, written justification must be provided for this conclusion.*

Step Three: ***Score proposals.*** Committee members should **INDIVIDUALLY** score the proposals based on the criteria established within the RFP. Please send me your individual scores by **12:00 Noon, June 5, 2019.** I will prepare a summary team score for all scorers.

Step Four: ***Evaluation Committee Meeting***. Once the proposals have been evaluated and scored by the individual committee members, the entire committee will meet to discuss the proposals and arrive at the final scoring. The committee should discuss all aspects of the proposals so that there is a "unified understanding" of the criteria and corresponding responses. Individual scores may be adjusted at this point based upon discussion. If any of the scores change I will prepare a new summary team rating. The highest score on the Summary Team score will be awarded the business.

Step Five: ***Discussion/Negotiation.*** This step is optional. If the committee is unsure of certain items or issues included in the RFP response, it may request further clarification from the vendor. The Purchasing department will distribute clarification questions to applicable vendor/s. Upon receipt of the vendor responses, the Purchasing department will distribute to the committee members.

Step Six: ***Best and Final Offer.*** This step is optional. A letter asking the vendors to submit a "Best and Final Offer" may be issued by the Purchasing department at the request of the evaluation committee. Once a "Best and Final Offer" is received, the committee will evaluate it in the same manner as the original Proposal.

Step Seven: ***Recommendation and Review.*** After the final scores from the above steps are tallied, the Purchasing department will contact the successful vendor and initiate the agreement process. Upon contract execution, the Purchasing department will notify the remaining vendors, informing them of our decision to award the business elsewhere.

PROPOSAL RATING INSTRUCTIONS:

The attached proposal evaluation form is to be used to initially rate and score proposals. Please enter your scores in the "raw score" fields of the Evaluation Score Sheet. *Please forward to my attention, an electronic version of your completed Evaluation Score Sheet no later than* ***12:00 Noon, June 5th****. The initial results will be presented at the meeting and will form the basis of our discussion.*

- EVALUATION CRITERIA

  Evaluation criteria and respective weights are as follows:

Evaluation Criteria	**Raw Possible Points**	**Weight Factor**	**Total Possible Score**
Letter of Transmittal Requirements, Proposal Organization, completeness of response	5	10%	0.50
Process: Vendor can perform all aspects of the Contract, knowledge of industry, proper qualifications, can handle our size and needs	5	25%	1.25
Related experience: Years, Worked with Vendors similar to CalOptima, References	5	20%	1.00
Account Team: Qualifications, Location, Experience	5	15%	0.75
Price	5	20%	1.00
Contract Changes (Purchasing Only)	5	10%	0.50

  With the four different evaluation criteria, there is a total of 30 "raw points" available for each Proposal. Each evaluation criteria has been weighted in proportion to its perceived value to the overall score.

  Each criterion should be rated separately from the others. In other words, if vendor "A" appears highly capable of effectively completing the project/providing the service, has very good qualifications and related experience, but in your opinion, does not have competitive rates, you should not downgrade your score for the first two criteria as punishment for not doing well on the other criteria categories. It is perfectly acceptable to give vendor "A", a higher score for the first two criteria, and a lower score on the other applicable criteria.

  The Evaluation Team will only need to input their scores in the rows entitled "raw score" of the attached electronic Evaluation Score Sheet.

- PROPOSAL CRITERIA RATINGS (0-5)

  Please rate each Proposal on a scale of 0-5 for each evaluation criteria. This scale and the meaning of the ratings are as follows:

  5 - Outstanding - far exceeds minimum requirements, offers prospects of extremely high-quality work product.

4 - Very Good - exceeds minimum requirements, offers prospects of very high work product.

3 - Good - meets minimum requirements, although there are deficiencies which may result in some flawed work products.

2 - Barely adequate - several deficiencies which may result in flawed work product.

1 - Deficient - does not meet requirements, poses virtual certainty of high risk of flawed products and generally inadequate performance.

0 - Totally non-responsive and noncompetitive to the RFP.

- SCORE (Maximum 5 points)

  Raw Possible Points Evaluation Rating x Weight/Factor = Total Possible Score
  The maximum weighted score for any given Proposal is 5 points.

Reminder….. The EVALUATION MEETING is scheduled for June 6th from 1:00pm – 2:00pm in conference room 802-S

I can be reached on ext. 8659 for any questions. Thank you.

Scope of Work

I. OBJECTIVE

CalOptima is seeking a CONTRACTOR to provide Mobile Text Messaging services to enhance member engagement. The successful Offeror must support CalOptima in implementing a secure communication program designed to close gaps in care, improve quality scores, drive higher engagement and satisfaction for CalOptima's members.

The successful Offeror will provide technology platform for managing outreach to CalOptima's members via text message. The interactive messages must operate as a reliable, secure, and high-speed messaging system of use in the health care environment.

II. MEMBERSHIP

CalOptima's membership is provided for reference only.

CalOptima Membership*

Program	Description	Members
Medi-Cal	California's Medicaid Program for low-income children, adults, seniors and people with disabilities	689,641
OneCare Connect	Medicare-Medicaid Plan for people who qualify for both Medicare and Medi-Cal, combining Medicare and Medi-Cal benefits, adding supplemental benefits for vision, transportation and dental services, and providing comprehensive care coordination	14,104
OneCare	Medicare Advantage Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal	1,417
PACE	Program of All-Inclusive Care for the Elderly for older adults, providing comprehensive health services through the CalOptima PACE center	394

**Membership Data as of January 31, 2020*

III. REQUIREMENTS

A. Comply with all state and federal regulations, including but not limited to FDA, Affordable Care Act (ACA), Centers for Medicare and Medicaid Services (CMS), the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **The Contractor shall be required to sign a Business Associate Agreement (BAA) prior to the commencement of the Contract.**

B. **MOBILE TEXT MESSAGING**

1. Text Campaign Strategy

   a. Successful Offeror's mobile text messaging services must be able to support specific initiatives to help increase member engagement and communications between CalOptima andthe member and. Please describe and/or provide any

samples to demonstrate how the Successful Offeror can support the following with targeted texting strategies:

- Quality Improvement (i.e. preferable experience in assisting health plans with improving HEDIS measures, preventive care, medication adherence, wellness, disease management, etc.)
- Health Plan Navigation Support (i.e. providing information on health care benefits, how to access CalOptima's programs or services such as Nurse Advice Line, assisting new enrollees on how to choose a doctor, etc.)
- Surveys to measure member satisfaction with CalOptima's services

2. Text Messaging Features
   a. Please describe the messaging features that are supported by the Successful Offeror. At minimum, they should include:
      - Text blasting/bulk messaging
      - Two-way text messaging
      - Tailored or personalized text messages
      - Automated responses
      - Keywork responses
      - Conditional branch logic (allow for keyword and automated responses based on predefined algorithm)
      - Message scheduling/staggering
      - Message queuing
      - Active links
      - Voting and polling
      - Short codes
      - Unicode support

3. Content

   a. Content must be written at a sixth-grade reading level or below to ensure the information is easy to understand. Please provide any details related to content development, required approvals, and customization options.

4. Enrollment

   a. Successful Offeror shall have policies and proecuedres for managing the users opt-out/opt-in and text preferences.

   b. Successful Offeror must be able to support CalOptima with identifying mobile numbers and land line numbers to distinguish users who are able to receive text messages.

IV. DATA EXCHANGE, SECURITY, AND SYSTEM INTERFACE REQUIREMENTS

A. The Successful Offeror must have a Health Insurance Portability and Accountability Act (HIPAA) compliant platform and secure encryption texting capability to ensure the safe management of Protected Health Information (PHI) and other sensitive data. Please share the process, policies and/or procedures Successful Offeror will follow to ensure HIPAA regulations are met and certified as HIPAA compliant.

B. Successful Offeror shall have the ability to handle eligibility files and to download from CalOptima's FTP site. It shall also have the ability to take the eligibility files and set-up a system load.

C. Successful Offeror must ensure that all data is kept for ten (10) years at minimum.

D. Successful Offeror agrees, upon termination of the relationship (regardless of which party terminates), to provide all information required for successful transition files at no additional cost.

V. CULTURAL AND LINGUISTICS

A. CalOptima supports seven (7) "threshold" languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese, and Arabic. Successful Offeror shall have ability to support mobile text messaging services in English and Spanish, at minimum. Please list any other languages that are supported by the Sum.

VI. REPORTING

A. Successful Offeror's reporting mechanisms should be able to provide real-time updates of text message delivery and campaign performance. Describe what information is captured on these reports.

B. Summary reports shall be provided at the conclusion of each text campaign that measures performance and outcomes. Describe the report features and the data elements that are captured.

C. Reports should be in a format that allows data to be integrated into CalOptima systems. How will data be shared with CalOptima (i.e. web portal, secure email, FTP transfer, etc)?

D. Does the Offeror include any analysis in the standard reporting package?

E. All offerors shall provide a sample copy of the reports with its proposals.

VII. SERVICE LEVEL AGREEMENT (SLA)

What Service Level Agreements and warranties does your company provide? Please provide detail levels and metrics. Include a specific time element offered.

VIII. IMPLEMENTATION SCHEDULE

Offeror shall provide an implementation timeline, including benchmarks and milestones as part of its response.

IX. PRICING MODEL

Offeror shall provide pricing model/structure for implementation, services provided and any other fees CalOptima may incur.

TEXTING PROGRAM & CAMPAIGN

SUBMISSION FORM

INSTRUCTIONS:
This form is required for all Medi-Cal managed care plans' (MCP) texting program and/or its individual texting campaign(s). Complete this form, including the Indemnification Agreement and email it to your DHCS Contract Manager for approval. DHCS will review and respond within 60 days of submission of the form.

Email subject line must include "For your approval: MCP name, Subplan name if applicable, Texting, and Campaign(s). For example:

- For a campaign submission: "For your approval: PlanA_Texting_New Member Orientation"
- For multiple campaigns submission: "For your approval: PlanA_Texting_Multiple Campaigns"

MCP is required to complete **all sections (Sections A-C)** when MCP first seeks an approval for a new Texting Program. Once MCP's new texting program has been approved and MCP would like to add additional campaigns, MCP will need to complete **Section A** and **Section C** only.

MCP can replicate **Section C** for additional campaigns if MCP desires to submit multiple campaigns for approval at the same time.

As a condition of approval for any text messaging campaign, a designee within the MCP who holds signatory authority is required to execute the attached Indemnification Agreement. Approval of the campaign is not considered final until the MCP receives a signed copy of the Indemnification Agreement back from the DHCS.

Key definitions

1. Texting Program: MCP's overall program design and infrastructure utilized to implement individual text messaging campaigns.
2. Texting Campaign: MCP's specific text message(s) aimed to address an identified objective (e.g., Preventive Care Reminders, New Member Orientation, etc.).

SECTION A: GENERAL INFORMATION

1. Managed Care Plan: _____ Date: _____
2. Submitted on behalf of a subcontracting MCP: _____ ☐ N/A
3. List the county or counties where you conduct your texting campaign(s):

   _____

SECTION B: TEXTING PROGRAM POLICY & PROCEDURE

1. Does the MCPs policy describe the process the MCP will use to obtain Members' Agreement to Participate (i.e., release of information) either through active opt-in or assumed opt-in approach and explain how a member can opt-out and the timeline associated with processing such requests? Please attach MCP's program policy and procedure (PnP) and process workflow. If no, please describe.

   ☐ Yes

   ☐ No

2. Does MCP's policy describe any financial costs that MCP's Members may incur from receiving the Agreement to Participate message(s) and any potential costs of future messages? If no, please describe.

   ☐ Yes

   ☐ No

3. Is the MCPs proposal related to redetermination outreach?

   ☐ Yes

   ☐ No

If yes, does the MCPs policy indicate outreach will only be made to members who are on the MCPs monthly 834 file showing an HCP status of 05?

☐ Yes

☐ No

4. Has the MCP provided texting script(s) to obtain MCP's Members' Agreement to Participate, or texting script(s) to allow MCP's members to opt-out?

☐ Yes

☐ No

5. Are the texting script(s) provided to members at the sixth grade reading level, per Exhibit A, Attachment 13, 4(C) of the contract with DHCS?

☐ Yes

☐ No

6. Does the texting script have any health education information? If yes, has the campaign script been reviewed and approved by the MCP health educator in accordance with APL 18-016?

☐ Yes

☐ No

7. Does the MCPs policy describe how the MCP considers privacy concerns and custody/guardianship situations based upon information available to MCP? If no, please describe.

☐ Yes

☐ No

8. Does the MCPs policy describe how the MCP protects Members' PII and/or PHI and meet requirements of Exhibit G of the contract with DHCS? If no, please describe.

☐ Yes

☐ No

9. Is the MCP using a third-party vendor? If yes, who is the vendor? If MCP has not already sent the vendor's Master Service Agreement and all contract amendments to DHCS, attach them to this application.

☐ Yes

☐ No

10. Does the vendor's Master Service Agreement comply with all applicable state and federal law and contract requirements in particular, Exhibit G of the contract with DHCS?

☐ Yes

☐ No

SECTION C: [SPECIFIC TEXTING CAMPAIGN NAME]

1. What is the overall purpose of campaign? Circle one.
    a. Providing health education information
    b. Providing written member information
    c. Reminding of preventive care visits
    d. Supporting statewide regulatory efforts on digital communications
    e. Other(s): _____

    Disclaimers: MCP certifies that any health education information provided through the campaign has been reviewed and approved by the MCP health educator in accordance with APL 18-016.

    Information on eligibility redetermination cannot be included in text campaign.

2. Describe the objectives of the campaign.

3. Does the campaign include any member incentives?

    ☐ Yes

    ☐ No

    If yes, has the incentive been reviewed and approved by DHCS health educators in accordance with APL 16-005?

    ☐ Yes

    ☐ No

4. Does the campaign include Personal Identification Information (PII) and/or Protected Health Information (PHI)? If yes, confirm the answer to question 7 in Section B above is checked "yes."

    ☐ Yes

    ☐ No

5. Who is the campaign's target population?

6. Who will be excluded from the campaign based upon information available to MCP (e.g., Members with SUDS, HIV/AIDS, behavioral health, minors in family planning, etc.)?

7. Does MCP require additional Members' Agreement to Participate for this specific texting campaign (i.e., extra opt-in requirement for sensitive services or PHI/PII content)?

   ☐ Yes

   ☐ No

8. What is the campaign length? When will it start and end?

9. What is the frequency of text messaging?

10. In what language(s) will the campaign be available? Will members have an option to receive text messages in their primary language (i.e. Spanish)?

11. Provide content script of the campaign.

12. What is the expected outcome of the campaign?

Attestations:

☐ For new campaign submission only (Section C), MCP attests that the Texting Program submission (Section B) that was previously approved contains no changes. Each new campaign will require an executed Indemnification Agreement.

☐ For ongoing texting programs, MCP will report to the DHCS Contract Manager the outcomes of plan texting campaigns on an annual basis, 45 days from the annual anniversary of the campaigns initiation. For time-limited campaigns, MCP will report outcomes six months after a program ends.

FOR DHCS USE ONLY (OR USE ALTERNATE DHCS AIR FORM)

1. DHCS Reviewer's Name: _____ Date: _____
2. DHCS Reviewer's Title: _____
3. DHCS Reviewer's Decision:

☐ Approved as submitted

☐ Approved with the following changes:

_____

☐ Denied

Reason (s): _____

_____

☐ Request for more information: _____

_____

_____

TEXT MESSAGING CAMPAIGN INDEMNIFICATION AGREEMENT

In consideration of the Department of Health Care Services' approval of [INSERT HEALTH PLAN NAME's] text messaging program, [INSERT HEALTH PLAN NAME] agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred to the extent DHCS is required to provide notice to affected beneficiaries and any other costs associated with any actual or alleged breach of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 and the Information Practices Act, California Civil Code section 1798 et seq. by [INSERT HEALTH PLAN NAME] and any vendor, contractor, subcontractor that [INSERT HEALTH PLAN NAME] contracts with for the approved text messaging campaign.

_____	_____
Health Plan Representative	DHCS Contract Manager
_____	_____
Date	Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 7, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Approval of CalOptima Population Health Management Strategy for 2019

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality and Analytics, (714) 246-8400

Recommended Action

Consider approval of the CalOptima Population Health Management Strategy for 2019.

Background

The National Committee for Quality Assurance (NCQA) continuously assesses the health care landscape, as well as pending regulations, to enhance accreditation standards annually. Effective July 1, 2018, NCQA implemented a significant change by creating a new Population Health Management (PHM) Standards section (see Attachment 2). Concurrently, NCQA eliminated the Disease Management standards, moved Complex Case Management (CCM) Standards from the Quality Management & Improvement Standards (QI) section, and Wellness and Prevention Standards from the Member Connections Standards (MEM) section to the PHM section. The PHM section also included new standards requiring health plans to provide Delivery System Supports, such as providing transformation support to the primary care practitioners. The comprehensive PHM Strategy is the first structural requirement of the new standard set. In preparation for the next NCQA re-accreditation and onsite audit scheduled for July 11-12, 2021, CalOptima must start implementing the PHM Strategy with appropriate resource alignment starting on May 24, 2019 upon Board approval.

Discussion

The intent of the CalOptima PHM Strategy for 2019 is to develop a comprehensive plan of action for addressing our culturally diverse member needs across the continuum of care. The community driven plan of action is based on numerous efforts to assess the health and well-being of CalOptima members. The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The year one approach of the CalOptima PHM Strategy is to align current and new programs (e.g., Bright Steps, Behavioral Health Integration, Whole-Child Model, Complex Case Management, and Health Management Programs, etc.) to the new PHM framework leveraging internal and external population health needs assessment findings to date. The PHM plan of action as part of the Quality Improvement (QI) Work Plan is updated annually through the comprehensive annual QI Program and Evaluation process. In addition to the cost and quality performance data sets, CalOptima's PHM strategy is adjusted annually based on the analysis of other data sources that reflect the changing demographics and local population needs of the Orange County community.

Back to Agenda Back to Item

The PHM Strategy addresses four focus areas:

1. Keeping members healthy
2. Managing members with emerging risk
3. Patient safety or outcomes across all settings
4. Managing multiple chronic conditions.

Building upon the current high touch Model of Care and expanding its relevant care components to provide access to quality health care services to a broader member population, the CalOptima PHM Strategy proposed innovative ways to provide members with access to quality health care services leveraging secured virtual technology. CalOptima will be testing the feasibility of various telehealth use cases, ranging from the traditional e-consult, remote patient monitoring, and texting applications, to non-medical virtual visits in member's home.

Additionally, the PHM Strategy proposed new strategies to support providers in the delivery system transformation.

1. Practice Site Transformation - Develop CalOptima Quality Improvement nursing expertise to serve as Quality Advisors or Practices Facilitators to provide individualized technical assistance to improve member experience and patient safety at the practices starting with high volume safety net community centers.
2. Expand Provider Coaching and Leadership Development - Offer individual provider coaching sessions and office staff workshops to improve quality of services and patient experience, especially targeting high volume practices with high incidences of Quality of Services (QOS) grievances.

Fiscal Impact

There is no additional fiscal impact for the recommended action to approve the CalOptima PHM Strategy for Calendar Year 2019. The Fiscal Year 2018-19 Operating Budget approved by the Board on June 7, 2018, included funding to start implement the PHM Strategy by May 2019.

Rationale for Recommendation

These recommendations reflect alignment between CalOptima Population Health Strategy with the NCQA's new standards to provide integrated quality healthcare services to CalOptima's population at large, including those members who are currently healthy and low emerging risk. The timely implementation of the PHM Strategy by May 2019, will position CalOptima well to achieve NCQA re-accreditation aiming for Excellence accreditation status in 2021.

Concurrence

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

Attachments

1. CalOptima Population Health Management (PHM) Strategy for 2019
   a. 2018 NCQA PHM Standards
2. 2019 NCQA PHM Standards and Guidelines
3. PowerPoint Presentation to Board of Directors' Quality Assurance Committee: CalOptima PHM Strategy - 2019 Overview

/s/ Michael Schrader *1/30/2019*
Authorized Signature **Date**

CalOptima Population Health Management (PHM) Strategy

PHM Strategy Description [PHM1 A]

BACKGROUND

Who We Are

Orange County is unique in that it does not have county-run hospitals or clinics. CalOptima was created in 1993 by a unique and dedicated coalition of local elected officials, hospitals, physicians, and community advocates. It is a county organized health system (COHS) authorized by State and Federal law to administer Medi-Cal (Medicaid) benefits in Orange County, and is the largest COHS nationwide. As a public agency, CalOptima is governed by a Board of Directors with voting members from the medical community, business, county government and a CalOptima member. CalOptima's mission is to provide members with access to high quality health services delivered in a cost-effective and compassionate manner.

CalOptima contracts with the State of California Department of Health Care Services (DHCS) to arrange and pay for covered services to Medi-Cal members, and also contracts with the Centers for Medicare & Medicaid Services (CMS) for Medicare-reletad programs. As of October 2018, CalOptima's total membership is more than 775,000, which includes members in Medi-Cal; a Medicare Advantage SNP; a Cal MediConnect Plan (Medicare-Medicaid); and the Program for All-Inclusive Care for the Elderly (PACE).

Medical services are delivered to CalOptima's Medi-Cal members through a variety of contractual arrangements. As of May 2018, CalOptima contracts with 13 health networks, including four Health Maintenance Organizations (HMOs), three Physician/Hospital Consortia (PHCs) composed of a primary medical group and hospital, and five Shared Risk Medical Groups (SRGs). CalOptima is able to fulfill its mission in Orange County because of its successful partnership with its outstanding providers.

Intent

CalOptima has a comprehensive plan of action for addressing our culturally diverse member needs across the continuum of care. The community driven plan of action is based on numerous efforts to assess the health and well-being of CalOptima members. The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe,

effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

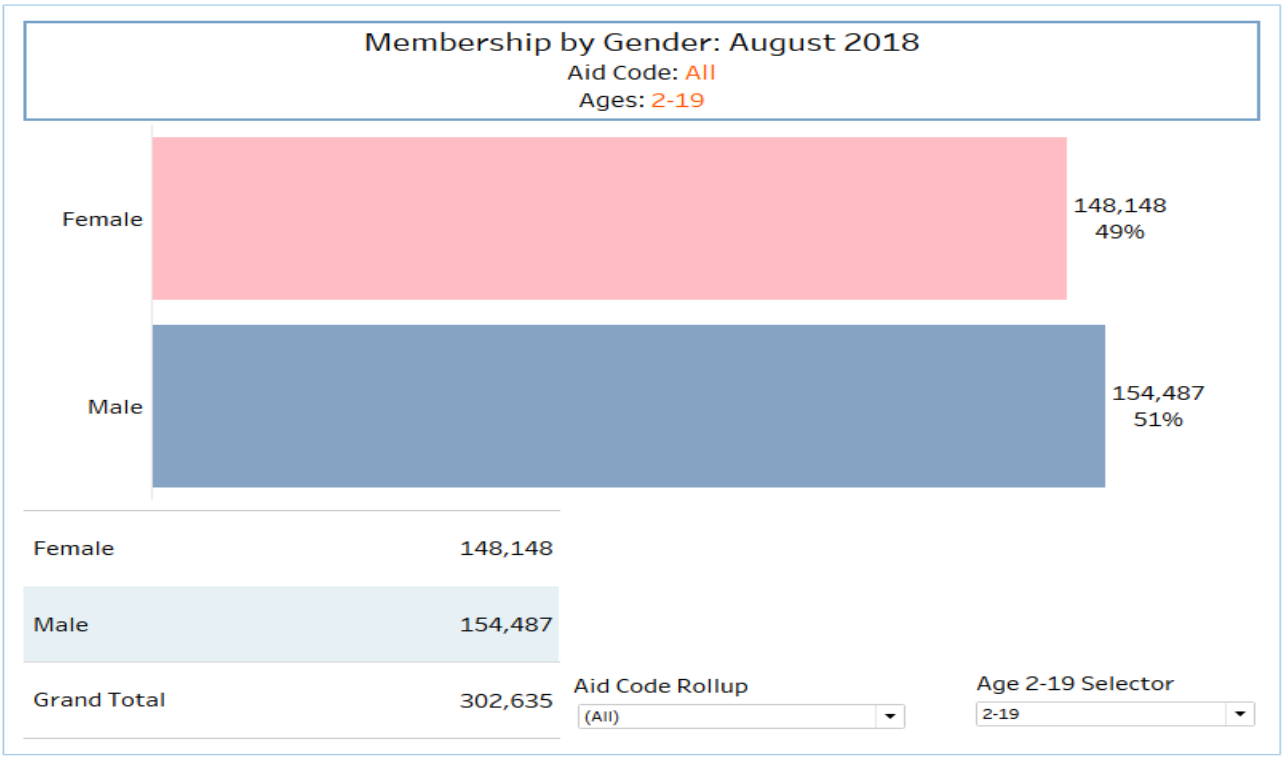
- **CalOptima's Target Population**
  - **Population Identification [PHM2]**
    - CalOptima identifies and assesses its population through a variety of efforts and uses the findings for appropriate interventions. One of many sources that the PHM Strategy is based upon is the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. The PHM plan of action addresses the unique needs and challenges of specific ethnic communities, including economic, social, spiritual, and environmental stressors, to improve health outcomes. The PHM plan of action, as part of the Quality Improvement (QI) Work Plan, is updated annually through the comprehensive annual QI Program Evaluation process. In addition to the cost and quality performance data sets, CalOptima's PHM strategy is adjusted annually based on the analysis of other data sources that reflects the changing demographics and local population needs of the Orange County community. Since CalOptima members represent 25% of Orange County residents, other examples of external reports used to help identify trends that may impact CalOptima population are identified below.
      - The 2016 Orange County Community Indicators Report
      - The 2017 Conditions of Children in Orange County Report
      - Children eligible for California Children's Services (CCS) Report from the county CCS Program
      - Prenatal Notification Report (PNR)
  - **Data Integration [PHM2 A]**
    - CalOptima integrates multiple internal and external data sources in its data warehouse to support population identification and various PHM functions. Some examples of internal and external data sources are:
      - Member data from the Department of Health Care Services (DHCS)
      - Medical and Behavioral claims from DHCS and Orange County Health Care Agency (OC HCA) Mental Health inpatient claims
      - Encounters data from contracted health networks
      - Pharmacy claims
      - Laboratory claims and results from Quest and LabCorp
      - Other advanced data sources (e.g., member data of homeless status from Illumination Foundation, Regional Center of Orange County, Utilization Management (UM) authorization data, and qualitative data from health appraisals)

- **CalOptima Population and Sub-Population Segments [PHM2 B]**
  - In addition to external data sources, CalOptima leverages Tableau, an enterprise analytic platform, for segmenting and stratifying our membership, including the subsets to which members are assigned (e.g. high-risk pregnancy, multiple inpatient admissions, co-morbid conditions, disabilities, polypharmacy, high risk and high cost cases, transgender population etc.). The Enterprise and Quality Analytics departments provide standard and ad hoc reports specifying the numbers of members in each category and the programs or services for which they are eligible.

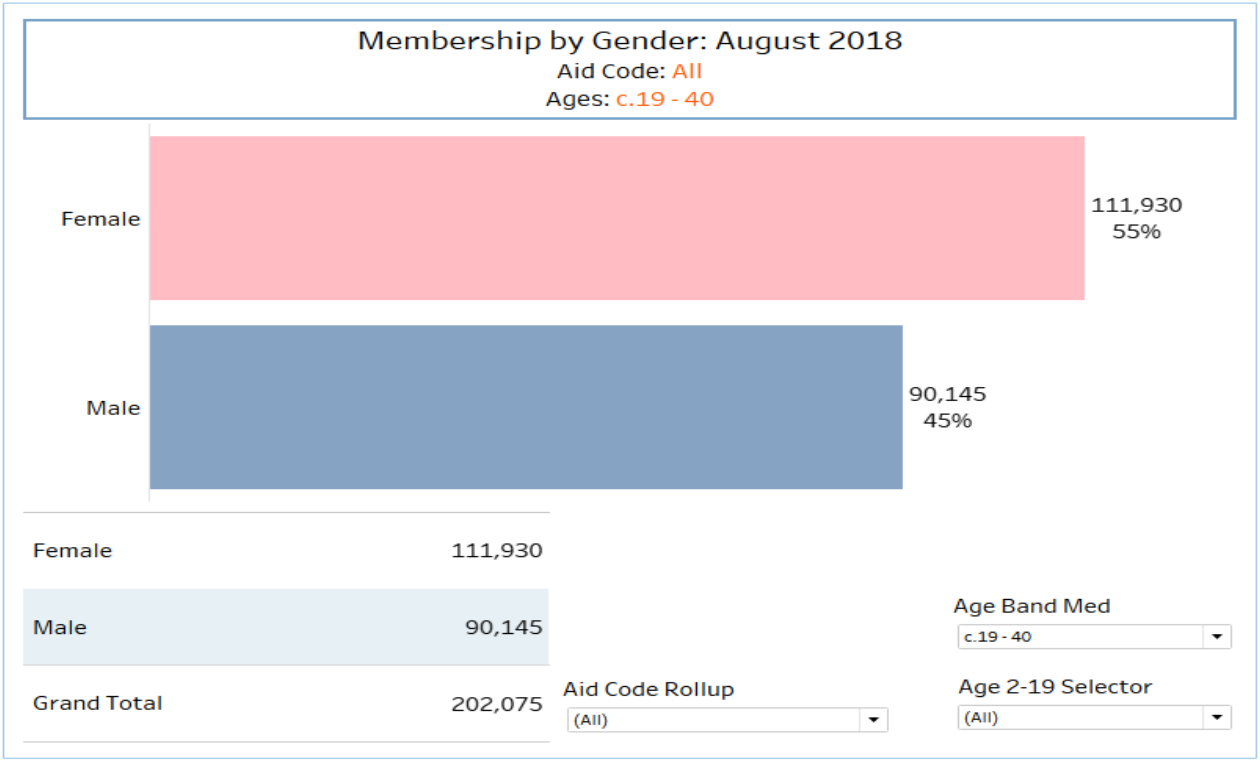
    Example of Member Segmentation – *Source: Tableau_f_dx_v33_m95_08.24.18*

  - *By Age and Gender*

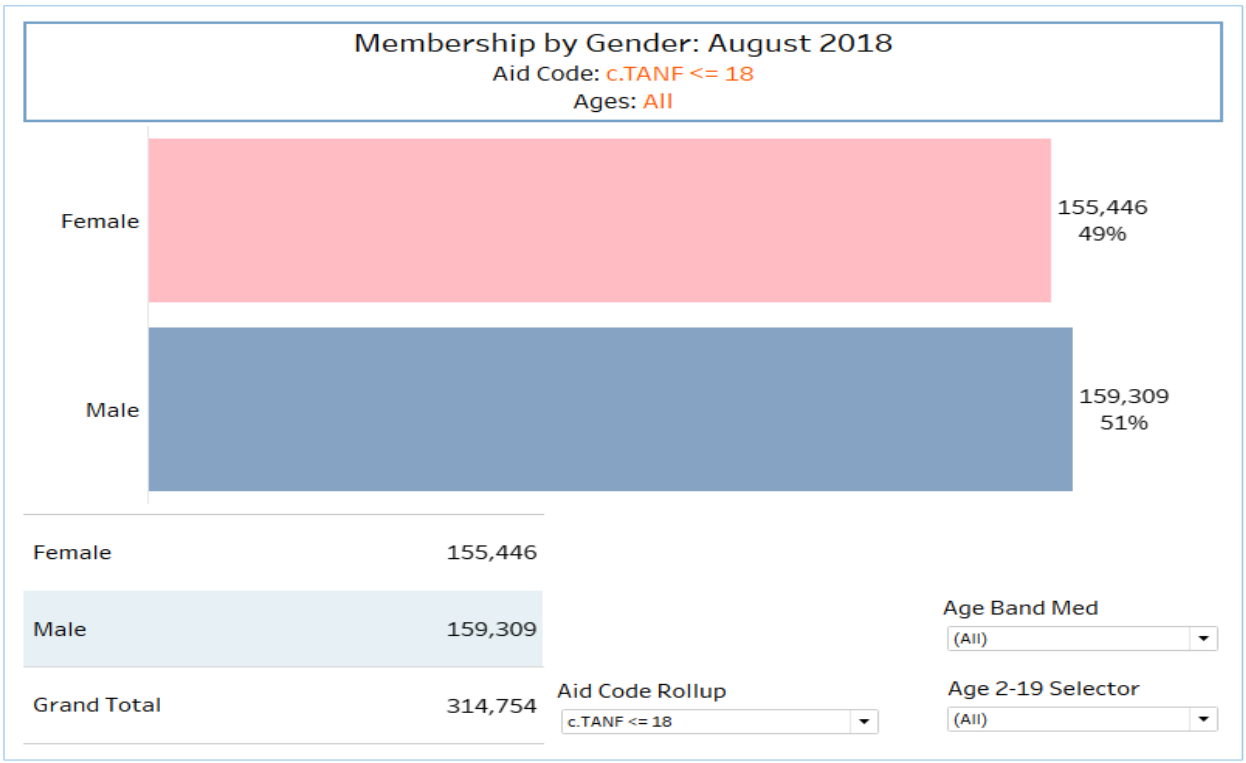
    - *Ages 2–19*



- *Adults 19–40*

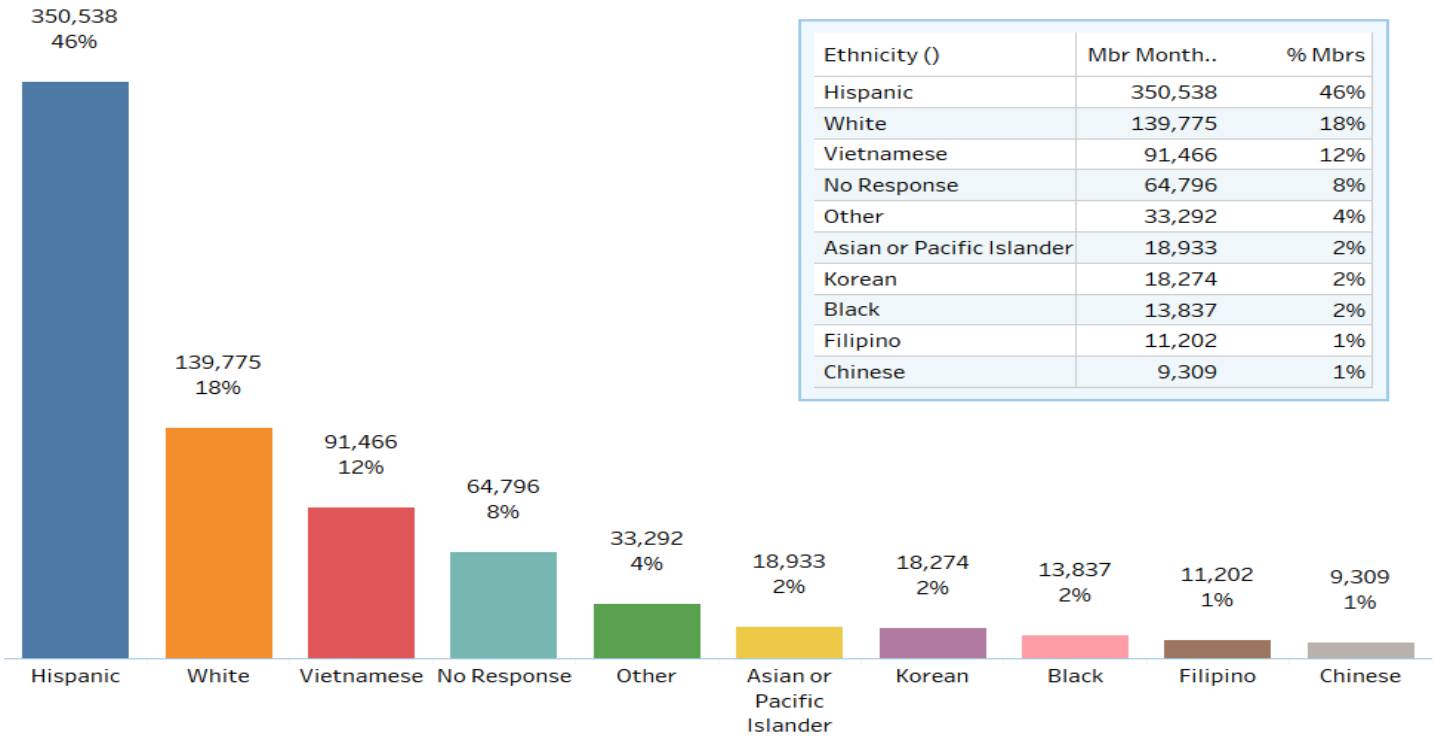


- *TANF (<18 Non-SPD)*



- *Ethnicity*

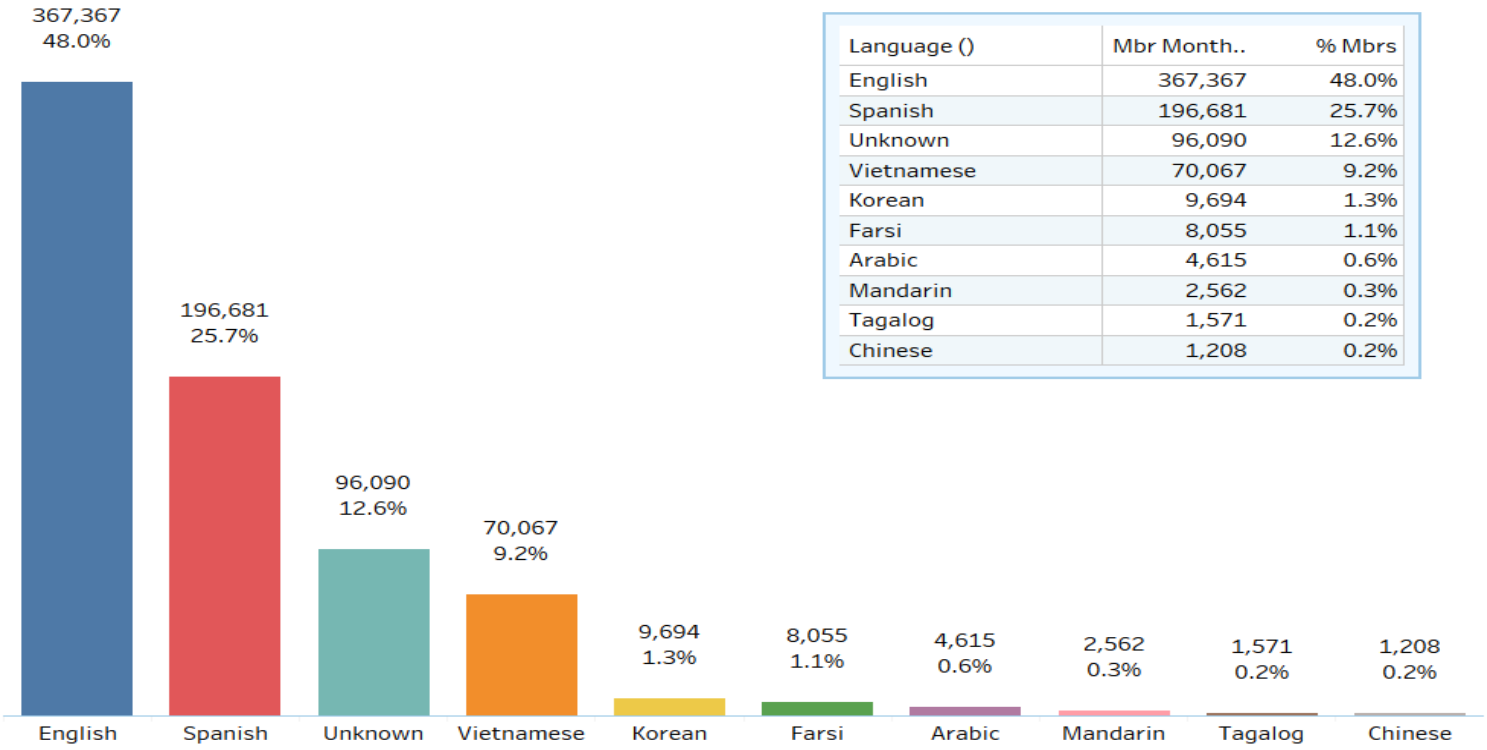
CalOptima Top Ten Member Ethnicities
Aid Code: All
Ages: All
Total Members: 764,774



Ethnicity ()	Mbr Month..	% Mbrs
Hispanic	350,538	46%
White	139,775	18%
Vietnamese	91,466	12%
No Response	64,796	8%
Other	33,292	4%
Asian or Pacific Islander	18,933	2%
Korean	18,274	2%
Black	13,837	2%
Filipino	11,202	1%
Chinese	9,309	1%

- *Language*

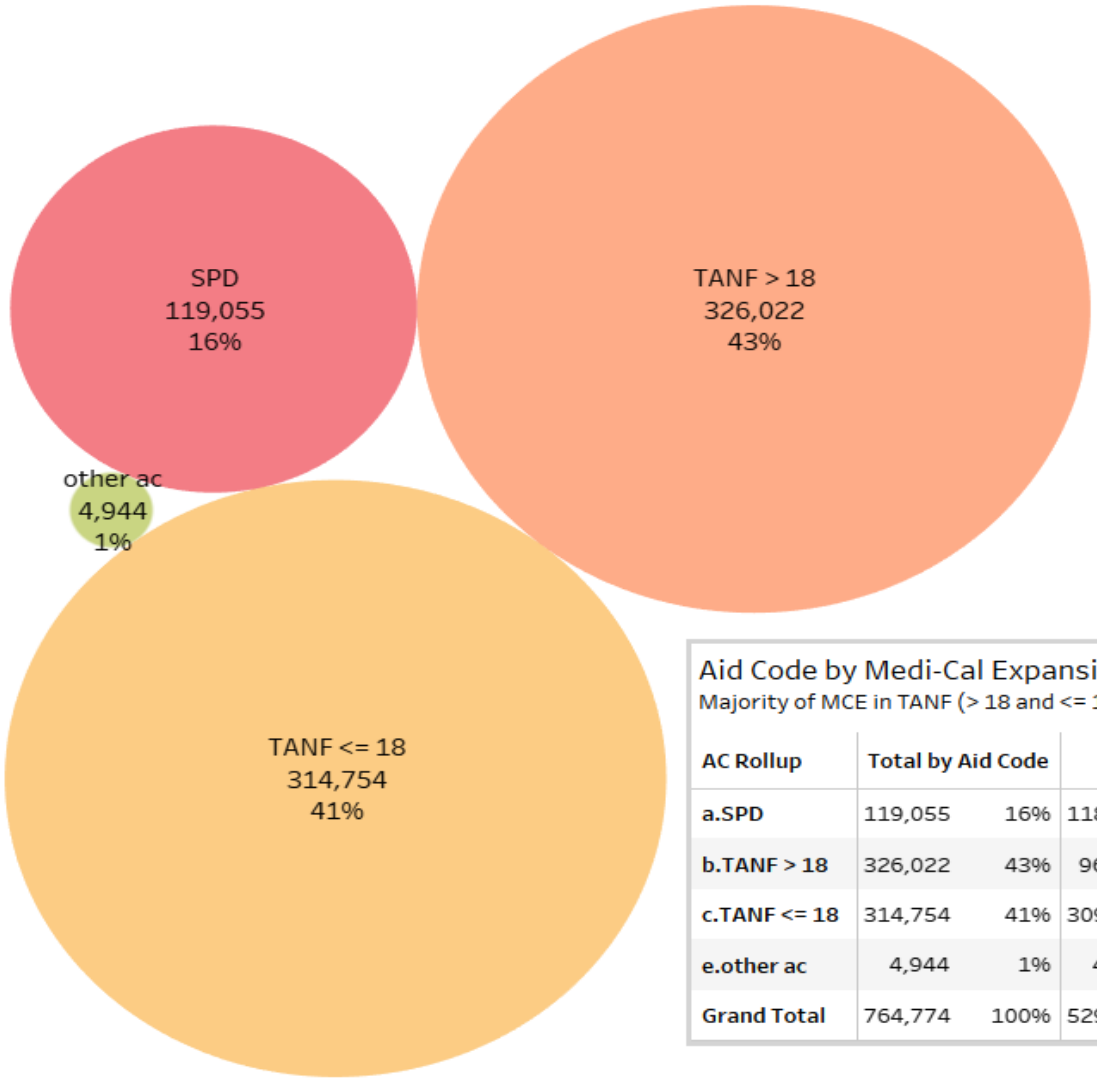
CalOptima Top Ten Member Languages
Aid Code: All
Ages: All
Total Members: 764,774



Language ()	Mbr Month..	% Mbrs
English	367,367	48.0%
Spanish	196,681	25.7%
Unknown	96,090	12.6%
Vietnamese	70,067	9.2%
Korean	9,694	1.3%
Farsi	8,055	1.1%
Arabic	4,615	0.6%
Mandarin	2,562	0.3%
Tagalog	1,571	0.2%
Chinese	1,208	0.2%

- *By Aid Code*

Membership by Aid Code: August 2018

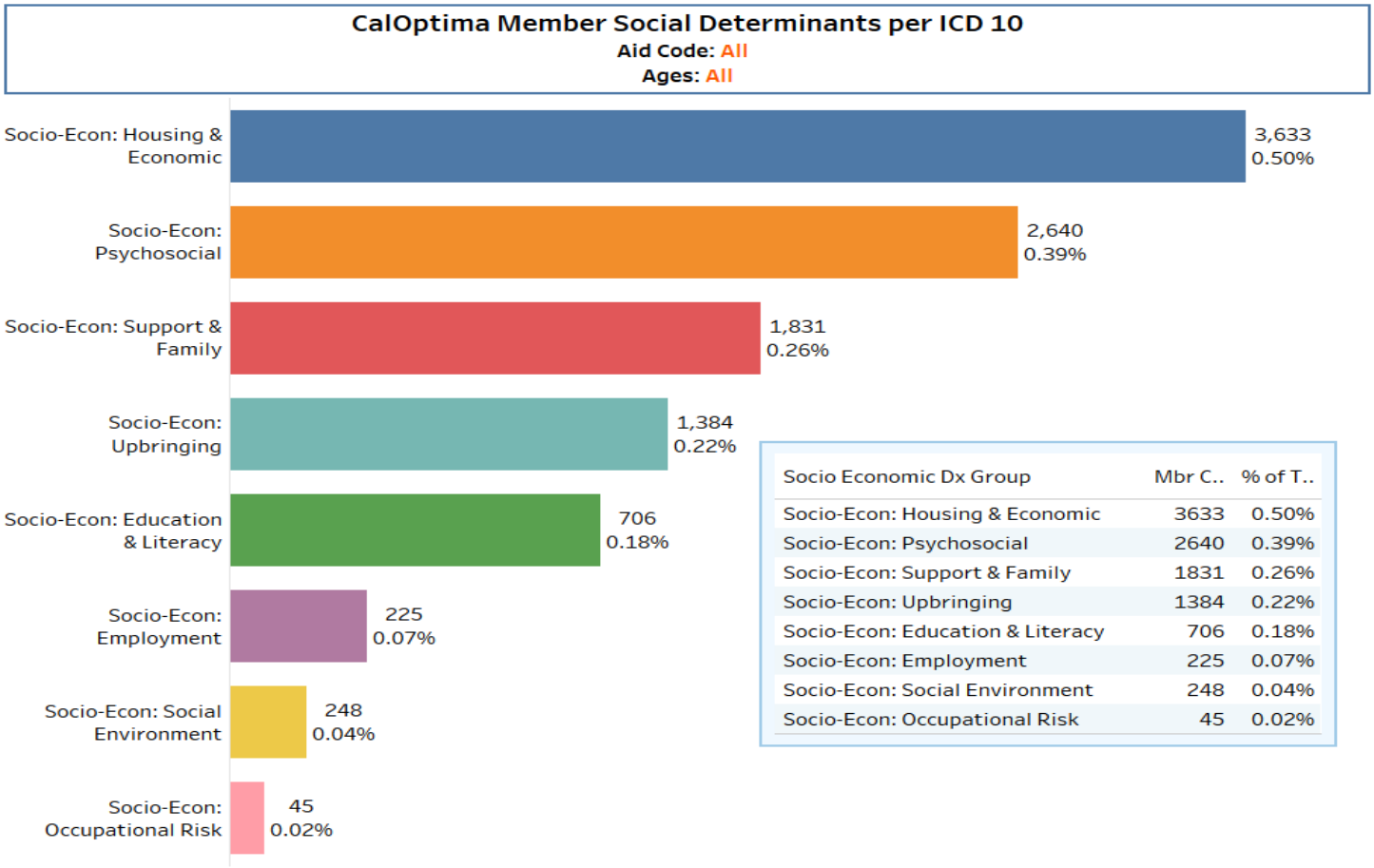


Aid Code by Medi-Cal Expansion (MCE)

Majority of MCE in TANF (> 18 and <= 18) aid codes

AC Rollup	Total by Aid Code		Not MCE		MCE	
a.SPD	119,055	16%	118,657	22%	398	0%
b.TANF > 18	326,022	43%	96,110	18%	229,912	98%
c.TANF <= 18	314,754	41%	309,583	58%	5,171	2%
e.other ac	4,944	1%	4,944	1%		
Grand Total	764,774	100%	529,294	100%	235,481	100%

- *Social Determinants*



Socio Economic Dx Group	Mbr C..	% of T..
Socio-Econ: Housing & Economic	3633	0.50%
Socio-Econ: Psychosocial	2640	0.39%
Socio-Econ: Support & Family	1831	0.26%
Socio-Econ: Upbringing	1384	0.22%
Socio-Econ: Education & Literacy	706	0.18%
Socio-Econ: Employment	225	0.07%
Socio-Econ: Social Environment	248	0.04%
Socio-Econ: Occupational Risk	45	0.02%

➢ **Other Sub-Populations**
- Women during pregnancy
- Children with obesity
- Children with California Children's Services (CCS) eligible condition
- Children and adults with autism
- Adult with disability and chronic conditions
- Persons with substance abuse disorder
- Persons requiring organ transplants
- Person with multiple chronic conditions and homelessness
- Frail elderly adults at risk for institutional care
- Transgender population
- Persons at end of life

❖ **Population Assessment [PHM2 B]**

➢ CalOptima conducts an annual population health risk assessment through analysis of quality performance trends, including Healthcare Effectiveness Data and Information Set (HEDIS) results, member experience surveys in all threshold languages by Health Networks, members complaints and grievances trends, and

inpatient utilization trends. To date, CalOptima serves eligible Medi-Cal beneficiaries from birth to 111 years of age! CalOptima serves a broad spectrum of population with health care needs from the cradle to the grave. Our population segments include well infants, children, adolescents, young adults, pregnant mothers, children with disabilities, children with CCS conditions, well adults, adults with chronic conditions and disabilities, members with serious and persistent mental illness (SPMI), well seniors, frail elderly with deteriorating functional status, and members residing in long-term care (LTC) facilities. The sub-populations include, but are not limited to, populations with health disparities due to race and ethnicity, transgender identity, food insecurity, and homelessness. As the Orange County demographic assessment changes every five years, CalOptima conducts a comprehensive Member Health Needs Assessment of Orange County residents to assess the characteristics and needs of the member population in the community we serve.

2019 PHM STRATEGY

- **Strategies to Keep Members Healthy [PHM1 A Factor 1, 2]**
  - **Bright Steps — Improve Prenatal and Postpartum Care**
    - **Goal:** Demonstrate significant improvement in prenatal and postpartum care rates to achieve 90th percentile by December 2020
      - Improve 2018 HEDIS Prenatal Care rates (83.6%) from the 50th percentile to 75th percentile over a 24-month period.
      - Improve 2018 HEDIS Postpartum Care rates (69.44%) from 75th percentile to 90th percentile over a 24-month period
    - **Target Population:** Members in the first trimester of pregnancy newly identified through the pregnancy notification form.
    - **Description of Programs or Services:** CalOptima contracts with certified Comprehensive Perinatal Service Program (CPSP) providers to deliver evidenced-based prenatal and postpartum care to members. Bright Steps is designed to support CalOptima Medi-Cal moms through a healthy pregnancy and postpartum care. Annually the program will be evaluated for increased Prenatal and Postpartum Care (PPC) HEDIS rate, reduced rates for neonatal intensive care unit usage, reduced number of low birth weights and preterm births, and member satisfaction with the program.
    - **Activities:** CalOptima staff provide member outreach and coordination with CPSP providers. In areas with limited CPSP providers, CalOptima staff will provide direct health education and support program interventions aligned with the CPSP guidelines.

- **Shape Your Life — Prevent Childhood Obesity**
  - **Goal:** Maintain 2018 HEDIS Rates of 90th percentile or greater for Weight Assessment and Counseling for Nutrition and Physical Activity for following Children/Adolescents (WCC) measures year-over-year:
    - BMI Percentile (WCC)
    - Counseling for Nutrition (WCC)
    - Counseling for Physical Activity (WCC)
  - **Target Population:** Members age 5-18 with a Body Mass Index (BMI) equal to or above the 85th percentile.
  - **Description of Programs or Services:** CalOptima's Shape Your Life health education and physical fitness activity program aims to increase youth member access to weight management program(s), increase doctor/patient communication regarding healthy weight and nutrition and physical activity counseling, and increase member nutrition and physical activity knowledge and improve behaviors. Annually the program will be evaluated for program effectiveness. Measurement goals include pre/post BMI, knowledge gains (pre/post validated survey) and member satisfaction with program.
  - **Activities:** The program uses the licensed Kids-N Fitness curriculum which is evidenced-based and validated through Children's Hospital Los Angeles. Interventions includes up to 12 group classes, which include nutrition education and physical activity, and an incentive for a follow up visit with provider after 6 consecutive classes. All classes are conducted in members' community using appropriate threshold language of the participants.

- **Strategies to Manage Members with Emerging Risk [PHM1 A Factor 1,2]**
  - **Health Management Programs — Improving Chronic Illness Care Prevention and Self-Management**
    - **Goals:** Develop chronic illness program interventions to support improvements in HEDIS and Member Experience scores
      - Demonstrate significant improvement in 2018 HEDIS measures related to chronic illness management for Asthma Medication Ratio (AMR), Medication Management for People with Asthma (MMA), Monitoring for Patients on Persistent Medications (MPM), Controlling Blood Pressure (CBP), and Comprehensive Diabetes Care (CDC)
      - Increase overall Member Satisfaction by improving Rating of All Health Care to 90th Percentile by 2021
      - Reduce ED and IP rates by 3% for program participants in 2018
    - **Target population:** Members discovered to be at risk for Asthma, Diabetes and/or Heart Failure based on primary care physician referral, new diagnosis codes, or pharmacy claims. Specific criteria detailed below.

- Members > 3 (Asthma); Members > 18 (Diabetes, Heart Failure) for Medi-Cal, OneCare, and OneCare Connect line of business
- Two year look back period for Asthma, Diabetes, or Heart Failure Related Utilization
- Exclusion Criteria:
  - Ineligible CalOptima Members
  - Members Identified for LTC or diagnosed with Dementia
  - Members Delegated to Kaiser

- **Description of Programs or Services:** CalOptima's Health Management Programs focus on disease prevention and health promotion for members with Asthma, Diabetes and Heart Failure. Health Management Programs are designed to improve the health of our members with low acuity to moderate-risk chronic illness requiring ongoing intervention. To assess the effectiveness of each Health Management Program, measures are set annually against organization or national benchmark standards. The evaluation takes into consideration program design, methodology, implementation and barriers to provide an analysis with quantitative and qualitative results for CalOptima's population with chronic illness. Measurement goals for each program include improvement in HEDIS measures related to the chronic conditions managed, reduced IP/ED for members with chronic illness, and member satisfaction with health management program.
- **Activities:** Health education using evidence-based clinical practice guidelines and self-management tools, relevant to members for the provision of preventive, acute, or chronic, medical services and behavioral health care services standards and requirements. *(Refer activities list in Policies and Procedures GG.1211.)*

➢ **Opioid Misuse Reduction Initiative — Prevent and Decrease Opioid Addiction**

- **Goal:** Decrease the prevalence of opioid use disorder by implementing a comprehensive pharmacy program by December 2019
- **Target Population:** Members with diagnosis of opioid substance abuse disorder
- **Description of Programs or Services:** A multi-departmental and health collaborative aim at reducing opioid misuse and related death.
- **Activities:** Includes, but is not limited to, pharmacy lock-in program, physician academic detailing for safer prescribing, increased access to Medication Assisted Treatment (MAT), and case management outreach.

❖ **Strategies to Ensure Patient Safety [PHM1 A Factor 1,2]**

➢ **Behavioral Health Treatment (BHT) Services**

- **Goal:** Establishing appropriate program baseline in 2019
- **Target Population:** Children with Autism Spectrum Disorder (ASD) who are eligible Medi-Cal members under 21 years of age, as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.
- **Description of Programs or Services:** Provide medically necessary BHT services to children with Autism Spectrum Disorder through early identification and early intervention in collaboration with the parents to promote optimal functional independence before aging out of the Regional Center system. BHT is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior.
- **Activities:** Treatments include direct observation, measurement, and functional analysis of the relations between environment and behavior of children with ASD.

➢ **Practice Facilitation Team — Improve Practice Health & Safety Leveraging the QI Practice Facilitators Team**

- **Goals**: Achieve and sustain 100% compliance in all Facility Site Review (FSR) audits year-over-year for primary care practices.
- **Target Population:** Medi-Cal adults and children accessing primary care.
- **Description of Programs or Services:** Enhancing the existing FSR nursing function by training nurses in QI facilitation skills to address any gaps from FSR audits to improve compliance with practice health and safety standards at the practice sites of the CalOptima Community Networks (CCN).
- **Activities:** CalOptima will develop Practice Facilitator functions for the FSR nurses to identify opportunities to improve practice site health and safety and provide QI technical assistance to these practices to achieve zero defect patient safety at the primary care practices. CalOptima will coordinate with the community clinics, Federally Qualified Health Centers (FQHC), and eventually expand to other potential settings such as PACE to promote patient safety practices.

❖ **Strategies to Manage Members with Multiple Chronic Illnesses [PHM1 A Factor 1,2]**

➢ **Whole-Child Model — Ensure Whole-Child-Centric Quality and Continuity Care for Children with CCS Eligible Conditions**

- **Goal:** Improve Children and Adolescent Immunization HEDIS measures by 10% from the 2018 baseline by December 2020 (excluding children and adolescent under cancer treatment)
  - Improve Childhood Immunization Status Combo10 for Children with CCS eligible conditions to ≥37.0% (2018 Baseline = 33.3 %)
  - Improve Immunization for Adolescents with CCS eligible conditions to ≥ 50.0% (2018 Baseline = 45.33%)
- **Targeted Population:** Children with CCS Eligible Conditions
- **Description of Programs or Services:** The WCM program is designed to help children receiving CCS services and their families get better care coordination, access to care, and to promote improved health results. Currently, children who have CCS-eligible diagnoses are enrolled in and get care from both the county CCS program for their CCS condition and CalOptima for their non-CCS conditions, routine care and preventive health. Beginning July 1, 2019, Orange County Medi-Cal CCS eligible children will receive services for both CCS and non-CCS conditions from CalOptima. Children whose CCS care will be transitioning under WCM to CalOptima on July 1, 2019, are referred to as Transitioning WCM members.
  Activities: CalOptima identifies children with potentially eligible CCS conditions. Upon confirmation of CCS Program eligibility, CalOptima assigns a Personal Care Coordinator (PCC) to each Member. The PCC assists the members and family to navigate the health care system, accessing high quality primary care providers, CCS-paneled specialists, care centers and Medical Therapy Units. The primary goal is facilitation of timely, appropriate health care and coordination among the health care team, especially including the member and family.

➢ **Health Home Program (HHP) — Improve clinical outcomes of members with multiple chronic conditions and experiencing homelessness**
- **Goal:** Establishing baseline measures in 2019
  - Member Engagement Rate
  - Inpatient Readmissions
  - Emergency Department (ED) Visits
- **Target Population:** DHCS identified list of *highest risk 3-5 % of the Medi-Cal members with multiple chronic conditions meeting the following eligible criteria:*
  - Specific combination of physical chronic conditions and/or substance use disorder (SUD) or specific serious mental illness (SMI) condition;
  - Meet specified acuity/complex criteria

- Eligible members consent to participate and receive Health Home Program services.

- **Description of Programs or Services:** A pilot program of enhanced comprehensive care management program with wrap-around non-clinical social services for members with multiple chronic conditions and homelessness.
- **Activities:** Core services as defined by DHCS are detailed below.
  - Comprehensive care management
  - Health promotion
  - Care coordination
  - Individual and family support services
  - Comprehensive transitional care
  - Referral to community and social support services
  - Other new services
    - Accompany participants to critical appointments
    - Provider housing navigation services for members experiencing homelessness
    - Manage transition from non-hospital or nursing facility settings, such as residential treatment programs
    - Trauma informed care

❖ **PHM Activities and Resources [PHM 1A Factor 3]**

➢ CalOptima will use our annual population assessment to review and update our PHM structure, activities and resources. The annual population assessment helps CalOptima to set new program priorities, re-calibrate existing programs, re-distribute resources to ensure health equity, and proactively mitigate emerging risk, such as partnering with Orange County Health Care Agency to address social determinants that adversely impacting the health and wellness of the CalOptima member population and relevant sub-populations.

➢ As the various health care sectors adopt technology to address the changing demographic of the population and bring needed care to members in non-traditional ways, CalOptima will be exploring the feasibility of advancing our mission to provide members with access to quality health care services leveraging advanced virtual technology. In order to bring timely care and services to a broader population, CalOptima will explore the feasibility of leveraging telehealth usage in cases ranging from the traditional e-consult, remote patient monitoring, and texting applications, to non-medical virtual visits in members' homes.

❖ **Expanding Strategies to Inform Members Leveraging Technology [PHM1 A5, PHM B]**

➢ CalOptima deploys multiple methods for informing members about PHM programs and services. Based on the members' language preferences, members

are informed of various health promotion programs, and how to contact Care Management, via the initial Member Packet in the mail, CalOptima website, personal telephone outreach or Robo calls, in person, and by email. One of the PHM strategies to support members age 19–40 is to develop telehealth technology enhanced methods of informing members, such as text or other mobile applications.

- CalOptima PHM programs are accessible to eligible Orange County Medi-Cal beneficiaries who meet the PHM program criteria.
- CalOptima provides instruction on how to use these services in multiple languages and at appropriate health literacy levels.
- CalOptima honors member choice; hence, all the PHM programs are voluntary. The members can decline the program or opt out any time.

❖ **Delivery System for Practitioner/Provider Support [PHM3 A]**

- **Information Sharing**
  - CalOptima Provider Relations and QI departments provide ongoing support to practitioners and providers in our health networks, such as sharing patient-specific data, offering evidenced-based or certified decision-making aids and continuing education sessions, and providing comparative quality and cost information. CalOptima will continue to improve information sharing with Health Network providers using integrated and actionable data.
- **Practice Transformation Technical Assistance (New Idea)**
  - One of the PHM strategies is to offer practice transformation support through Lean QI training, practice site facilitations and/or individualized technical assistance to improve member experience.
- **Provider Coaching and Leadership Development (New Idea)**
  - Offer individual provider coaching sessions and office staff workshops to improve quality of services and patient experience, especially targeting high volume practices and the top 30 providers with high volume grievances and potential quality of services issues.
  - Allocate one scholarship to sponsor community clinic physician leadership development through the California Health Care Foundation (CHCF) Health Care Leaders Fellowship.
- **Pay for Value [PHM3 B]**
  - CalOptima already incentivizes providers based on quality performance in its directly contracted CalOptima Community Network (CCN) and the contracted Health Networks.

❖ **Population Health Management Impact [PMH 6]**

- **Measuring Effectiveness**
  - CalOptima annually conducts a comprehensive analysis of the PHM strategy's impact and effectiveness as part of the annual QI Program evaluation. The comprehensive analysis includes quantitative results for relevant clinical, cost, utilization, and qualitative member experience.

CalOptima regularly compares its performance results with external benchmarks and internal goals. The results are reviewed and interpreted by the interdisciplinary team through various QI Committees. Given the capability of Tableau, an enterprise analytic platform, CalOptima has the capability to conduct longitudinal QI Program Evaluation to ensure sustained effectiveness year over year.

- **Improvement and Action**

- Based on the annual PHM program evaluation using internal and external data, CalOptima annually updates its QI Work Plan to improve CalOptima's PHM program and act on at least one opportunity for improvement within each of the quality domains as define in the CalOptima Quality Improvement Program.

***APPENDICES**:*

2018 NCQA PHM Standards

Overview

Notable Changes for 2018

Changes to the Policies and Procedures

- ***Section 1***
  - Clarified that a Medicaid-only organization that manages CHIP members included those members in its Medicaid product line.
  - Described how to navigate NCQA's web-based application process.
  - Clarified, under "Organization Obligations," that a Discretionary Survey is based on the standards in effect during the discretionary survey.
- ***Section 2***
  - Added reference to government requirements under "State and Federal Agency Surveys."
  - Added URL for NCQA Guidelines for Advertising and Marketing (http://www.ncqa.org/marketing.aspx) under "Marketing accreditation results"
  - Added PHM 1, Element A to the list of elements with critical factors.
- ***Section 3:***
  - Added "Web-based survey platform" subhead and text.
  - Replaced QI 5 with PHM 4 under "File review results."
- ***Section 4***

  Added a note about Federal Medicaid Rule: §438.332 regarding state deeming survey results.
- ***Section 5***
  - Updated English-speaking USA and Canada fraud hotline number to 844-440-0077.
  - Updated language under "Notifying NCQA of Reportable Events" subhead and added "Annual Attestation of Compliance With Reportable Events" and "NCQA Investigation" subheads and text.
  - Updated language under "Mergers and Acquisitions and Changes to Operations" subhead.
- ***Section 6***
  - Described how to navigate NCQA's Web-based application process.

Changes to the standards and guidelines

- New category, Population Health Management (PHM):
  - *PHM 1: PHM Strategy.*
  - *PHM 2: Population Identification.*
  - *PHM 3: Delivery System Supports.*
  - *PHM 4: Wellness and Prevention.*
  - *PHM 5: Complex Case Management.*
  - *PHM 6: Population Health Management Impact.*
- Moved the following standards to the PHM category:
  - *QI 5: Complex Case Management (PHM 5).*
  - *MEM 1: Health Appraisals (PHM 4,* Elements A–G).
  - *MEM 2: Self-Management Tools (PHM 4,* Elements H–K).

- Eliminated the following standards and elements:
  - *QI 5:*
    - Element B: Complex Case Management Program Description.
    - Element C: Identifying Members for Case Management.
    - Element J: Measuring Effectiveness.
  - *QI 6: Disease Management.*
  - *QI 7: Practice Guidelines.*
  - *MEM 7: Support for Healthy Living.*
  - *UM 4,* Element H: Appropriate Classification of Denials.
- Added a factor to NET 3, Element A: Assessment of Member Experience Accessing the Network.
- Renumbered the QI and MEM standards to account for standards and elements that were incorporated into the PHM category or eliminated.

Changes to the appendices

- ***Appendix 1***
  - Updated points for all evaluation options to account for new PHM category and eliminated QI standards, UM 4, Element H and MEM standards.
- ***Appendix 2***
  - Added new measures for the commercial, Medicare and Medicaid product lines. Refer to the table below.

Measure		Commercial	Medicare	Medicaid
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NA	NA	✓
IET	Initiation and Engagement of Alcohol & Other Drug Dependence Treatment—*Initiation of AOD Treatment rate*	✓	✓	✓
PSA	Non-Recommended PSA-Based Screening in Older Men	NA	✓	NA
EDU	Emergency Department Utilization	✓	✓	NA
SPC	Statin Therapy for Patients With Cardiovascular Disease—*Both rates*	✓	✓	✓
SPD	Statin Therapy for Patients With Diabetes—*Both rates*	✓	✓	✓
IMA	Immunizations for Adolescents (Combination 2)	✓	NA	✓

  - Retired the measures listed in the table below.

Measure		Commercial	Medicare	Medicaid
ABA	Adult BMI Assessment	Retain	✓	Retain
CDC	Comprehensive Diabetes Care—*Medical Attention for Nephropathy rate*	✓	✓	✓
	Comprehensive Diabetes Care—*HbA1c Poor Control (>9%) rate*	✓	✓	✓
MSC	Medical Assistance With Smoking and Tobacco Use Cessation —*Advising Smokers to Quit rate*	✓	Retain	Retain
IMA	Immunizations for Adolescents (Combination 1)	✓	NA	✓

- ***Appendix 3***
  - Updated points reporting category based on changes in appendix 1.

- ***Appendix 4***
  - Updated calculation of HEDIS score based on changes in appendix 2
- ***Appendix 5***
  - Updated standards and elements eligible for automatic credit based on the new PHM category and eliminated QI requirements. (Refer to *Appendix 5* for the list of changes.)

Accreditation: A Symbol of Quality and Improvement

Why NCQA?

Health plans accredited by NCQA demonstrate their commitment to delivering high-quality care through one of the most comprehensive evaluations in the industry, and the only assessment that bases results on clinical performance (i.e., HEDIS measures) and consumer experience (i.e., CAHPS measures). NCQA publicly reports quality results, allowing "apples-to-apples" comparison among plans. NCQA's Health Plan Accreditation program helps organizations demonstrate their commitment to quality and accountability.

Health plans choose NCQA Health Plan Accreditation because:

- **Employers want it.** Many employers—especially the Fortune 500 employers—do business only with NCQA-Accredited plans. They and other purchasers want to keep employees healthy and productive and maximize the value of their health investment by focusing on quality care. The National Business Coalition on Health's widely used eValue8 tool captures NCQA Accreditation status and HEDIS/CAHPS scores as an important indicator of a plan's ability to improve health, and health care.
- **It meets regulatory requirements.** NCQA Accreditation contains many of the key elements that federal law and regulations require for State Health Insurance and Marketplace plans. Forty-two states recognize NCQA Accreditation as meeting their requirements for Medicaid or commercial plans; 17 states mandate it for Medicaid. The Federal Employees Health Benefit Program accepts NCQA Accreditation.
- **Consumers are looking for quality.** As consumers become more responsible for managing their health care, consumer interest in choosing high-quality plans will grow. The standards focus on key patient protections that consumers, regulators, public purchasers and employers value.
- **It's flexible and comprehensive.** NCQA builds flexible, yet rigorous standards that apply to all types of health plans. Annual updates to accreditation standards support the fast-changing needs of regulators and the health care marketplace. NCQA's Health Plan Accreditation is the most widely recognized accreditation program in the United States.

The rigor and competitive pricing of NCQA's program represent an excellent value for health plans. NCQA supports the accreditation process through its publications, users' groups and educational programs, making the path to performance-based accreditation accessible and feasible.

Changes and Updates: *What's New in 2018?*

NCQA continuously assesses the health care landscape, as well as new and pending regulations, to enhance accreditation standards on an annual basis. The HPA 2018 focuses on a new category*:* Population Health Management (PHM).

New PHM Category: NCQA combined existing population health management related requirements from Health Plan Accreditation categories (Quality Management and Improvement [QI] and Member Connections [MEM]) and new requirements that reflect a broader, population-wide focus on care management. The update removes elements that no longer add value.

- ***Reasons for the update:*** NCQA's goal is to streamline evaluation of an organization's population health management strategy by consolidating PHM-related elements into one category. The new category provides flexibility in how plans manage their members and encourages health plans to work with the delivery system to deliver quality care.

Tracking Out-of-Network Requests: A new factor (3) in NET 3A: Assessment of Member Experience Accessing the Network expands tracking of out-of-network requests for services to all product lines.

- ***Reasons for the update:*** Network adequacy is an important area of concern for consumers and purchasers alike because it affects timely access to care and out-of-pocket costs among other areas. The intent of this requirement is that organizations monitor and identify issues of access to primary care services, behavioral healthcare services and other specialty services. Analysis of out-of-network data helps organizations understand why members seek out-of-network services. Finding ways to address these occurrences can lead to better member experience.

Marketplace Readiness

NCQA's Health Plan Accreditation is the superior choice for insurers offering Marketplace products. It provides a "glide path" to accreditation; plans with varied goals and capabilities can earn the NCQA seal. The glide path involves three options or steps:

1. **Interim Evaluation** is for organizations that need accreditation before or soon after they open for business. It focuses on insurers' policies and procedures, does not include HEDIS/CAHPS reporting.
2. **First Evaluation** is for organizations new to NCQA. HEDIS/CAHPS reporting is required only in the final year, helping plans prepare for their Renewal Evaluation.
3. **Renewal Evaluation** is available to NCQA-Accredited organizations seeking to extend their accreditation. HEDIS/CAHPS reporting is mandatory, and performance results count in the scoring.

Accreditation Scoring System

NCQA uses the standards and audited HEDIS/CAHPS results to evaluate an organization. Depending on the Evaluation Option selected, a total of 50 or 100 points is possible (i.e., performance against the standards accounts for 50 possible points; HEDIS results account for 50 possible points).

Organizations submit audited results for designated HEDIS measures for each product line/product brought forward for accreditation as required for the Evaluation Option selected. To ensure validity, accuracy and comparability, an NCQA-Certified HEDIS Compliance Auditor must audit the results. NCQA evaluates the organization's audited HEDIS results against established benchmarks and thresholds to determine the score.

Accreditation Status Levels

Because most organizations offer several product lines (i.e., commercial, Marketplace, Medicare, Medicaid), NCQA determines accreditation status by product line for HMO, POS PPO and EPO products. Each product line/product reviewed by NCQA earns one of the following accreditation status levels, based on evaluation of the organization's performance against the standards and HEDIS results (if applicable) and the Evaluation Option.

- Excellent.
- Commendable.
- Accredited.
- Provisional.
- Interim.
- Denied.

New: PHM Category of Standards

Health care expenditures account for 17 percent of the gross domestic product ($17 trillion) in the United States, estimated to be 20 percent by 2020.[3] Although health spending is the highest in the world, our life expectancy is significantly shorter than that of other industrialized nations. Guided by the Institute for Healthcare Improvement's (IHI) Triple Aim framework,[4] the federal government, states, health plans and other stakeholders are tackling these challenges through various initiatives. The Triple Aim framework has three main objectives: improve patient experience of care, improve the health of populations and reduce the per capita cost of health care.

NCQA emphasizes the Triple Aim throughout Health Plan Accreditation through its new standard category, Population Health Management (PHM). PHM addresses health at all points on the continuum of care, including the community setting, through participation, engagement and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions.[5]

This category's scope facilitates population health management, not public health—an important distinction. "Public health" is a broad term for the coordinated efforts of local, state and national health departments to improve the quality of health for insured and uninsured community members. "Population health management" supports care activities for a defined population.

The PHM standards establish basic expectations:

1. Organizations have a population health management strategy that focuses on the "whole person" and the member's entire care journey.
2. Organizations can provide wellness services (e.g., health appraisal administration, self-management tools) and intervene with highest-risk members (i.e., requiring complex case management).
3. Organizations have the flexibility to choose members/populations with which to intervene (including the specific population under complex case management).
4. Organizations are committed to supporting their delivery system to facilitate better health outcomes and encourage value-based decisions.

The PHM requirements were developed through literature reviews, Stakeholder Advisory Committee discussions, feedback from our public comment period and enhanced feedback from additional stakeholder advisory councils and groups.

Delivery System Support and Value-Based Payment Arrangements

NCQA recognizes the need to align organizations with the delivery system, including hospitals, accountable care entities, practitioners and PCMHs, and other vendors delivering care. Toward that end, NCQA recommends standards for delivery system supports, with elements that allow flexibility in how organizations support delivery system. The elements provide many methods to support providers and allow the health plans to determine which best fit their network arrangement and current delivery system capabilities. Through these requirements, NCQA intends to increase data sharing and transparency between plans and providers. Also, NCQA requires a report describing the organization's value-based payment arrangements to better understand the changing landscape of the healthcare market *(PHM 3: Delivery System Supports)*.

[3]CMS Strategy: The Road Forward 2013-2017. https://www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/Downloads/CMS-Strategy.pdf
[4]IMI Triple Aim Initiative. http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx
[5]Population Health Alliance. http://www.populationhealthalliance.org/research/understanding-population-health.html

Eliminated Elements

NCQA eliminated the following standards and elements. With these changes, the HPA focus shifts from single-condition evaluation to population health-based evaluation. Retired elements include:

- ***QI 5:***
  - Element B: Complex Case Management Program Description.
  - Element C: Identifying Members for Case Management.
  - Element J: Measuring Effectiveness.
  - Element K: Action and Remeasurement.
- ***QI 6:***
  - Element A: Program Content.
  - Element B: Identifying Members for DM Programs.
  - Element C: Frequency of Member Identification.
  - Element E: Interventions Based on Assessment.
  - Element F: Eligible Member Active Participation.
  - Element G: Informing and Educating Practitioners.
  - Element H: Integrating Member Information.
  - Element I: Experience With Disease Management.
  - Element J: Measuring Effectiveness.
- ***QI 7:***
  - Element A: Adoption of Guidelines.
  - Element B: Adoption of Preventive Health Guidelines.
  - Element C: Relation to DM Programs.
  - Element D: Performance Measurement.
- ***MEM 7:***
  - Element A: Identifying Members.
  - Element B: Targeted Follow-Up With Members.

Where to Find Specific Information

The *Standards and Guidelines* include policies and procedures, standards and elements, scoring guidelines and appendices.

Policies and Procedures

- Information on organizations eligible for accreditation.
- Responsibilities of organizations seeking accreditation.
- Information on applying for accreditation.
- Information on the survey tool and readiness evaluation.
- Information on reporting accreditation results.
- Information on annual reevaluation.
- Information on the Accreditation Survey process.
- Information on evaluating HEDIS results and calculating HEDIS scores.
- Information on the Reconsideration process.

Accreditation Standards, Organized by Category

- The standards, elements and factors.
- A summary of changes from the previous standards year.
- Scoring guidelines describing requirements for each standard, element and factor.
- Information about how an organization can demonstrate performance against the element's requirements.
- Data sources for demonstrating compliance with requirements.
- The scope of review.
- The look-back period.

Appendices

- Appendix 1: Standard and Element Points for 2018.
- Appendix 2: HEDIS and CAHPS Points for HEDIS Reporting Year 2018.
- Appendix 3: Points by Reporting Category for 2018.
- Appendix 4: Calculating the Total HEDIS Score.
- Appendix 5: Delegation and Automatic Credit Guidelines.
- Appendix 6: CMS Regions.
- Appendix 7: Merger, Acquisition and Consolidation Policy for Health Plan Accreditation and LTSS Distinction.
- Appendix 8: Answers to Commonly Asked Questions.
- Appendix 9: Glossary.
- Appendix 10: Summary of Changes for 2018.

Other Important NCQA Information

NCQA publications, user groups and educational programs facilitate the evaluation process. They help plans succeed by making the path to performance-based accreditation accessible and feasible. In addition to the web-based survey platform, NCQA provides a variety of information to help organizations prepare for Accreditation Surveys.

- NCQA produces many publications relevant to organizations. Call NCQA Customer Support at 888-275-7585 or go to the NCQA website (www.ncqa.org).
- Access policy clarifications from the NCQA Policy Clarification Support (PCS) system on the NCQA Web page (http://my.ncqa.org). General questions are usually answered within 2 business days; complex questions are usually answered within 30 days.
- Find corrections, clarifications and policy changes to this publication at http://www.ncqa.org/tabid/119/Default.aspx/
- Find frequently asked questions (FAQ) at http://ncqa.force.com/faq/FAQSearch FAQs are updated on the 15th of the month or on the first business day following the 15th of the month.
- Organizations that are involved in NCQA Accreditation and Certification activities are encouraged to join the Accreditation and Certification Users Group (ACUG). The ACUG provides a learning and development platform for members to discuss updates applicable to their organization's procedures. Membership benefits include a monthly newsletter; WebEx discussions; and vouchers for publications, educational conferences and Quality Compass. For more information, e-mail acug@ncqa.org or go to http://www.ncqa.org/programs/accreditation/accreditation-certification-users-group-acug for a full description of the program.

- Organizations collecting HEDIS data are encouraged to join the NCQA HEDIS Users Group (HUG) for technical assistance and guidance on interpreting measure specifications. Membership benefits include NCQA HEDIS and accreditation publications, newsletters, Internet seminars, discount vouchers for HEDIS conferences and publications and up-to-date technical information. For more information, e-mail hug@ncqa.org.
- NCQA educational seminars provide valuable information on NCQA standards, the survey process and HEDIS. Course offerings range from a basic introduction to NCQA standards and HEDIS measures to advanced techniques for quality improvement. Visit the NCQA website or call NCQA Customer Support at 888-275-7585.
- NCQA staff are available to help organizations determine the Evaluation Option for which they are eligible. Staff provide step-by-step guidance on the application process, which includes an overview of policies and procedures, the fee structure, timelines and survey preparation. Contact ApplicationsandScheduling@ncqa.org.

Other NCQA Programs

NCQA offers the following accreditation programs:

- Accountable Care Organization (ACO).
- Case Management (CM).
- Case Management for Long-Term Services and Supports Programs (CM-LTSS).
- Disease Management (DM).
- Managed Behavioral Healthcare Organization (MBHO).
- Wellness and Health Promotion (WHP).

NCQA offers the following certification programs:

- Accreditation in Utilization Management, Credentialing and Provider Network UM/CR/PN).
- Credentials Verification Organization (CVO).
- Disease Management (DM).
- Health Information Products (HIP).
- Physician and Hospital Quality (PHQ).
- Wellness and Health Promotion (WHP).

NCQA offers the following recognition programs:

- Diabetes Recognition (DRP).
- Heart/Stroke Recognition (HSRP).
- Patient-Centered Connected Care™
- Patient-Centered Medical Home (PCMH).
- Patient-Centered Specialty Practice (PCSP).
- Oncology Medical Home (PCMH-O).
- School-Based Medical Home (SBMH).

NCQA offers the following evaluation program:

- New York Ratings Examiner Reviews (NYRx).

NCQA offers the following distinction programs:

- Multicultural Health Care (MHC).
- Long-Term Services and Supports (LTSS).

NCQA offers the following distinction programs for recognized PCMHs:

- Patient Experience Reporting.
- Behavioral Health Integration.
- Electronic Quality Measures (eCQM) Reporting.

Note: *Organizations that contract with NCQA-Accredited or NCQA-Certified organizations can reduce their delegation oversight. Refer to* Appendix 5: Delegation and Automatic Credit Guidelines*.*

11/20/17: Add the following as the last bullet under "NCQA offers the following accreditation programs":
• Utilization Management, Credentialing and Provider Network (UM-CR-PN).
• Delete the first bullet under "NCQA offers the following certification programs" that reads:
• Accreditation in Utilization Management, Credentialing and Provider Network (UM-CR-PN).

Population Health Management

Standards for Population Health Management

PHM 1: PHM Strategy—*Refer to Appendix 1 for points*

The organization outlines its population health management (PHM) strategy for meeting the care needs of its member population.

Intent

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

Summary of Changes

Additions

- Added *PHM 1, Element A: Strategy Description* as a new element.

Clarifications

- Added "interactive contact" to the element stem (Element B).
- Updated the scope of review to state that NCQA reviews up to 4 randomly selected programs (Element B).
- Added language to address how the element will be reviewed for the 2019 Standards Year (Element B).

Element A: Strategy Description—*Refer to Appendix 1 for points*

The strategy describes:

1. **Goals and populations targeted for each of the four areas of focus.***
2. **Programs or services offered to members.**
3. **Activities that are not direct member interventions.**
4. **How member programs are coordinated.**
5. **How members are informed about available PHM programs.**

Critical factors: Score cannot exceed 20% if critical factors are not met.

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews a description of the organization's comprehensive PHM strategy. The strategy may be fully described in one document or the organization may provide a summary document with references or links to supporting documents provided in other PHM elements.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For Interim Surveys: Prior to the survey date.

For First and Renewal Surveys: 6 months.

Explanation

This element is a **structural requirement.** The organization must present its own materials.

Factor 1 is a **critical factor** that the organization must meet to score higher than 20% on this element.

The organization has a comprehensive strategy for population health management that *at minimum* addresses member needs in the following four areas of focus:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.

***Factors 1, 2:* Four areas of focus**

At a minimum, the description includes for each of the four areas of focus:

- Goals (factor 1).
- Populations targeted (factor 1).
- Program or services for each area of focus (factor 2).

Goals are measurable and connected to a targeted population. NCQA does not prescribe a definition of "program or services." Programs and services may be provided to members by the organization or by other entities.

***Factor 3:* Activities that are not direct member interventions**

The organization describes all activities conducted by the organization that support PHM programs or services not directed at individual members. An activity may apply to more than one areas of focus. The organization has at least one activity in place.

***Factor 4:* Coordination of member programs**

The organization coordinates programs or services it directs and those facilitated by providers, external management programs and other entities. The PHM strategy describes how the organization coordinates programs across potential settings, providers and levels of care to minimize the confusion for members being contacted from multiple sources. Coordination activities are not required to be exclusive to one area of focus and may apply across the continuum of care and to other organization initiatives.

***Factor 5:* Informing members**

The organization describes its methods for informing members about all available PHM programs and services. Programs and services include any level of contact. The organization may make the information available on its website; by mail, e-mail, text or other mobile application; by telephone; or in person.

Exceptions

None.

Examples

***Factors 1, 2:* Goals, target populations, opportunities, programs or services**

Keeping members healthy

- Goal: 55 percent of members in the targeted population report receiving annual influenza vaccinations.
  - Targeted populations:
    - Members with no risk factors.
    - Members enrolled in wellness programs.

  - Programs or services: Community flu clinics, e-mail and mail reminders, radio and TV advertisement reminding public to receive vaccine.
- Goal: 10 percent of targeted population reports meeting self-determined weight-loss goal.
  - Targeted population: Members with BMI 27 or above enrolled in wellness program.
  - Programs or services: Wellness program focusing on weight management.

Managing members with emerging risk

- Goal: Lower or maintain HbA1c control <8.0% rate by 2 percent compared to baseline.
  - Targeted population:
    - Members discovered at risk for diabetes during predictive analysis.
    - Members with controlled diabetes.
  - Programs or services: Diabetes management program.
- Goal: Improve asthma medication ratio (total rate) by 3 percent compared to baseline.
  - Targeted population: Diagnosed asthmatic members 18–64 years of age with at least one outpatient visit in the prior year.
  - Programs or services: Condition management program.

Patient safety

- Goal: Improve the safety of high-alert medications.
  - Targeted population: Members who are prescribed high-alert medications and receive home health care.
  - Activity: Collaborate with community-based organizations to complete medication reconciliation during home visits.

Outcomes across settings

- Goal: Reduce 30-day readmission rate after hospital stay (all causes) of three days or more by 2 percentage points compared to baseline.
  - Targeted population: Members admitted through the emergency department who remain in the hospital for three days or more.
  - Program or services: Organization-based case manager conducts follow-up interview post-stay to coordinate needed care.
  - Activity: Collaborate with network hospitals to develop and implement a discharge planning process.

Managing multiple chronic illnesses

- Goal: Reduce ED visits in target population by 3 percentage points in 12 months.
  - Targeted population: Members with uncontrolled diabetes and cardiac episodes that led to hospital stay of two days or more.
  - Programs or services: Complex case management.
- Goal: Improve antidepressant medication adherence rate.
  - Targeted population: Members with multiple behavioral health diagnoses, including severe depression, who lack access to behavioral health specialists.
  - Programs or services: Complex case management with behavioral health telehealth counseling component.

Factor 3: **Activities that are not direct member interventions**

- Data and information sharing with practitioners.
- Interactions and integration with delivery systems (e.g., contracting with accountable care organizations).
- Providing technology support to or integrating with patient-centered medical homes.

- Integrating with community resources.
- Value-based payment arrangements.
- Collaborating with community-based organizations and hospitals to improve transitions of care from the post-acute setting to the home.
- Collaborating with hospitals to improve patient safety.

Element B: Informing Members——*Refer to Appendix 1 for points*

The organization informs members eligible for programs that include interactive contact:

1. **How members become eligible to participate.**
2. **How to use program services.**
3. **How to opt in or opt out of the program.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For All Surveys: NCQA reviews the organization's policies and procedures in effect during the look-back period from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

For First Surveys and Renewal Surveys: For surveys beginning on or after July 1, 2019, NCQA also reviews materials sent to members from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

The score for the element is the average of the scores for all programs or services.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: 6 months for documented process.

Explanation

This element applies to PHM programs or services in the PHM strategy require interactive contact with members, including those offered directly by the organization.

Interactive contact

Programs with interactive contact have two-way interaction between the organization and the member, during which the member receives self-management support, health education or care coordination through one of the following methods:

- Telephone.
- In-person contact (i.e., individual or group).
- Online contact:
  - Interactive web-based module.
  - Live chat.
  - Secure e-mail.
  - Video conference.

Interactive contact does not include:

- Completion of a health appraisal.
- Contacts made only to make an appointment, leave a message or verify receipt of materials.

Distribution of materials

The organization distributes information to members by mail, fax or e-mail, or through messages to members' mobile devices, through real-time conversation or on its website, if it informs members that the information is available online. If the organization posts the information on its website, it notifies members that the information is available through another method listed above. The organization mails the information to members who do not have fax, e-mail, telephone, mobile device or Internet access. If the organization uses telephone or other verbal conversations, it provides a transcript of the conversation or script used to guide the conversation.

Factors 1–3: **Member information**

The organization provides eligible members with information on specific programs with interactive contact.

Exceptions

None.

Examples

Dear Member,

Because you had a recent hospital stay, you have been selected to participate in our Transitions Case Management Program. Sometime in the next three days, a nurse will call you to make sure you understand the instructions you were given when you left the hospital, and to make sure you have an appropriate provider to see for follow-up care. To contact the nurse directly, call 555-555-1234.

If you do not want to participate in the Transitions Case Management Program, let us know by calling 555-123-4567.

PHM 2: Population Identification—*Refer to Appendix 1 for points*

The organization systematically collects, integrates and assesses member data to inform its population health management programs.

Intent

The organization assesses the needs of its population and determines actionable categories for appropriate intervention.

Summary of Changes

Additions

- Added *PHM 2, Element A: Data Integration* as a new element.
- Added *PHM 2, Element D: Segmentation* as a new element.
- Split factor 1 into two factors, factors 1 and 2, updated scoring and added social determinants of health to factor 1 language (Element B).
- Added a new factor 3: "Review community resources for integration into program offerings to address member needs" (Element C).

Clarifications

- Updated the scope of review for First Surveys and Renewal Surveys to state "at least once during the prior year" (Element B).
- Updated the explanation to reflect population health management (Elements B, C).
- Updated the look-back period for all surveys to state "prior to the survey date" (Element C).

Element A: Data Integration—*Refer to Appendix 1 for points*

The organization integrates the following data to use for population health management functions:

1. **Medical and behavioral claims or encounters.**
2. **Pharmacy claims.**
3. **Laboratory results.**
4. **Health appraisal results.**
5. **Electronic health records.**
6. **Health services programs within the organization.**
7. **Advanced data sources.**

Scoring

100%	80%	50%	20%	0%
The organization meets 5-7 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

For Interim Surveys: NCQA reviews the organization's policies and procedures for the types and sources of integrated data.

For First and Renewal Surveys: NCQA reviews reports or materials (e.g., screenshots) for evidence that the organization integrated data types and data from sources listed in the factors. The organization may submit multiple examples that collectively demonstrate integration from all data types and sources, or may submit one example that demonstrates integration of all data types and sources.

Look-back period

For Interim, First and Renewal Surveys: Prior to the survey date.

Explanation

Data integration is combining data from multiple sources databases. Data may be combined from multiple systems and sources (e.g., claims, pharmacy), across care sites (e.g., inpatient, ambulatory, home) and across domains (e.g., clinical, business, operational). The organization may limit data integration to the minimum necessary to identify eligible members and determine and support their care needs.

***Factor 1:* Claims or encounter data**

Requires both medical and behavioral claims or encounters. Behavioral claim data are not required if all purchasers of the organization's services carve out behavioral healthcare services (i.e., contract for a service or function to be performed by an entity other than the organization).

Factors 2, 3

No additional explanation required.

***Factor 4:* Health appraisals**

The organization demonstrates the capability to integrate data from health appraisals and health appraisals should be integrated if elected by plan sponsor.

***Factor 5:* Electronic health records**

Integrating EHR data from one practice or provider meets the intent of this requirement.

***Factor 6:* Health service programs within the organization.**

Relevant organization programs may include utilization management, care management or wellness coaching programs. The organization has a process for integrating relevant or necessary data from other programs to support identification of eligible members and determining care needs. Health appraisal results would not meet this factor.

***Factor 7:* Advanced data sources**

Advanced data sources are those that aggregate data from multiple entities such as all-payer claims systems, regional health information exchanges or other community collaboratives. The organization must have access to use data from the source to meet the intent.

Examples

EHR integration

- Direct link from EHRs to data warehouse.
- Normalized data transfer or other method of transferring data from practitioner or provider EHRs.

Health services programs within the organization

- Case management.
- UM programs.
  - Daily hospital census data captured through UM.
  - Diagnosis and treatment options based on prior authorization data.
  - Health information line.

Advanced data sources may require two-way data transfer: The organization and other entities can submit data to the source and can use data from the same source. These include but are not limited to**:**

- Regional, community or health system Health Information Exchanges (HIE).
- All-payer databases.
- Integrated data warehouses between providers, practitioners, and the organization with all parties contributing to and using data from the warehouse.
- State or regionwide immunization registries.

Element B: Population Assessment—*Refer to Appendix 1 for points*

The organization annually:

1. **Assesses the characteristics and needs, including social determinants of health, of its member population.**
2. **Identifies and assesses the needs of relevant member subpopulations.**
3. **Assesses the needs of child and adolescent members.**
4. **Assesses the needs of members with disabilities.**
5. **Assesses the needs of members with serious and persistent mental illness (SPMI).**

Scoring

100%	80%	50%	20%	0%
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys, NCQA reviews the organization's policies and procedures

For First and Renewal Surveys, NCQA reviews the organization's most recent annual assessment reports.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

The organization uses data at its disposal (e.g., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to identify the needs of its population.

***Factor 1:* Characteristics and needs**

The organization assesses the characteristics and needs of the member population. The assessment includes the characteristics of the population and associated needs identified.

At a minimum, social determinants of health must be assessed. **Social determinants of health**[1] are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. The organization defines the determinants assessed.

[1]https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Characteristics that define a relevant population may also include, but are not limited to:

- Federal or state program eligibility (e.g., Medicare or Medicaid, SSI, dual-eligible).
- Multiple chronic conditions or severe injuries.
- At-risk ethnic, language or racial group.

Factor 2: **Identifying and assessing characteristics and needs of subpopulations**

The organization uses the assessment of the member population to identify and assess relevant subpopulations.

Factor 3: **Needs of children and adolescents**

The organization assesses the needs of members 2–19 years of age (children and adolescents). If the organization's regulatory agency's definition of children and adolescents is different from NCQA's, the organization uses the regulatory agency's definition. The organization provides the definition to NCQA, which determines whether the organization's needs assessment is consistent with the definition.

Factors 4, 5: **Individuals with disabilities and SPMI**

Members with disabilities and with serious and persistent mental illness (SPMI) have particularly acute needs for care coordination and intense resource use (e.g., prevalence of chronic diseases).

Exception

Factor 3 is NA for Medicare.

Examples

Factors 1, 2: **Relevant characteristics**

Social determinants of health include:

- Resources to meet daily needs.
- Safe housing.
- Local food markets.
- Access to educational, economic and job opportunities.
- Access to health care services.
- Quality of education and job training.
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
- Transportation options.
- Public safety.
- Social support.
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
- Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community).
- Socioeconomic conditions.
- Residential segregation.
- Language/literacy.
- Access to mass media and emerging technologies.
- Culture.

Physical determinants include:

- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change).
- Built environment, such as buildings, sidewalks, bike lanes and roads.
- Worksites, schools and recreational settings.
- Housing and community design.
- Exposure to toxic substances and other physical hazards.
- Physical barriers, especially for people with disabilities.
- Aesthetic elements (e.g., good lighting, trees, and benches).
- Eligibility categories included in Medicaid managed care (e.g., TANF, low-income, SSI, other disabled).
- Nature and extent of carved out benefits.
- Type of Special Needs Plan (SNP) (e.g., dual eligible, institutional, chronic).
- Race/ethnicity and language preference.

Element C: Activities and Resources——*Refer to Appendix 1 for points*

The organization annually uses the population assessment to:

1. **Review and update its PHM activities to address member needs.**
2. **Review and update its PHM resources to address member needs.**
3. **Review community resources for integration into program offerings to address member needs.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First and Renewal Surveys: NCQA reviews committee minutes or similar documents showing process and resource review and updates.

Look-back period *For Interim Surveys, First Surveys, and Renewal Surveys:* Prior to the survey date.

Explanation

***Factors 1, 2:* PHM activities and resources**

The organization uses assessment results to review and update its PHM structure, strategy (including programs, services, activities) and resources (e.g., staffing ratios, clinical qualifications, job training, external resource needs and contacts, cultural competency) to meet member needs.

***Factor 3:* Community resources**

The organization connects members with community resources or promotes community programs. Integrating community resources indicates that the organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population assessment.

Actively responding to member needs is more than posting a list of resources on the organization's website; active response includes referral services and helping members access community resources.

Examples

Community resources and programs

- Population assessment determines a high population of elderly members without social supports. The organization partners with the Area Agency on Aging to help with transportation and meal delivery.
- Connect at-risk members with shelters.
- Connect food-insecure members with food security programs or sponsor community gardens.
- Sponsor or set up fresh food markets in communities lacking access to fresh produce.
- Participate as a community partner in healthy community planning.
- Partner with community organizations promoting healthy behavior learning opportunities (e.g., nutritional classes at local supermarkets, free fitness classes).
- Support community improvement activities by attending planning meetings or sponsoring improvement activities and efforts.
- Social workers or other community health workers that contact members to connect them with appropriate community resources.
- Referrals to community resources based on member need.
- Discounts to health clubs or fitness classes.

Element D: Segmentation—*Refer to Appendix 1 for points*

At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Documented process, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For All Surveys: NCQA reviews a description of the method used.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's reports demonstrating implementation.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

Population segmentation divides the population into meaningful subset using information collected through population assessment and other data sources.

Risk stratification uses the potential risk or risk status of individuals to assign them to tiers or subsets. Members in specific subsets may be eligible for programs or receive specific services.

Segmentation and risk stratification result in the categorization of individuals with care needs at all levels and intensities. Segmentation and risk stratification is a means of

targeting resources and interventions to individuals who can most benefit from them. Either process may be used to meet this element.

Methodology

The organization describes its method for segmenting or stratifying its membership, including the subsets to which members are assigned (e.g., high risk pregnancy, multiple inpatient admissions). Organizations may use various risk stratification methods or approaches to determine actionable subsets.

Segmentation and stratification methods use population assessment and data integration findings (e.g., clinical and behavioral data, population and social needs) to determine subsets and programs/services members are eligible for. Methods may also include utilization/resource use or cost information, but methods that use only cost information to determine categories do not meet the intent of this element.

Reports

The organization provides reports specifying the number of members in each category and the programs or services for which they are eligible. Reports may be a "point-in-time" snapshot during the look back period.

Reports reflect the number of members eligible for each PHM program. They display data in raw numbers and as a percentage of the total enrolled member population, and may not add to 100% if members fall into more than one category.

PHM programs or services provided to members include, but are not limited to, complex case management. Reports must reflect the number of members eligible for each PHM program.

Examples

***Health Plan A:* Commercial HMO/PPO**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Pregnancy: Over 35 years, multiple gestation	High-risk pregnancy care management	55	0.5%
Type I Diabetes: Moderate risk	Diabetes management	660	6%
Tobacco use	Smoking cessation	110	1%
Behavioral health diagnosis in ages 15-19, rural	Telephone or video behavioral health counseling sessions	330	3%
Women of child-bearing age	Targeted women's health newsletter	3,850	35%
No risk factors	Routine member newsletters	2,750	25%
No associated data	None	3,850	35%

***Health Plan A:* Medicare**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Multiple chronic conditions	Complex case management: Over 65	2,000	5%
Over 65, needs assistance with 2 or more ADLs	Long-term services and supports	2,800	7%
COPD: High risk	Complex case management: Over 65	1,600	4%
Osteoporosis: High-risk women	Targeted member newsletter	8,800	22%
No risk factors	Routine member newsletters	6,000	15%
No associated data	None	4,800	12%

PHM 3: Delivery System Supports—*Refer to Appendix 1 for points*

The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements.

Intent

The organization works with practitioners or providers to achieve population health management goals.

Summary of Changes

Additions

- Added *PHM 3: Delivery System Supports* as a new standard.

Element A: Practitioner or Provider Support—*Refer to Appendix 1 for points*

The organization supports practitioners or providers in its network to achieve population health management goals by:

1. **Sharing data.**
2. **Offering certified shared-decision making aids.**
3. **Providing practice transformation support to primary care practitioners.**
4. **Providing comparative quality information on selected specialties.**
5. **Providing comparative pricing information for selected services.**
6. **One additional activity to support practitioners or providers in achieving PHM goals.**

Scoring

100%	80%	50%	20%	0%
The organization meets 3-6 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For *Interim Surveys*, NCQA reviews the organization's description of how it supports practitioners or providers.

For *First Surveys* and *Renewal Surveys*, NCQA reviews the organization's description of how it supports practitioners or providers and materials demonstrating implementation.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and *Renewal Surveys*: 6 months.

Explanation

The organization identifies and implements activities that support practitioners and providers in meeting population health goals. Practitioners and providers may include accountable care entities, primary or specialty practitioners, PCMHs, or other providers included in the organization's network. Organizations may determine the practitioners or providers with which they support.

***Factor 1:* Data sharing**

Data sharing is transmission of member data from the health plan to the provider or practitioner that assists in delivering services, programs, or care to the member. The organization determines the frequency for sharing data.

***Factor 2:* Certified shared-decision making aids.**

Shared decision-making (SDM) aids provide information about treatment options and outcomes. SDM aids are designed to complement practitioner counselling, not replace it. SDM aids facilitate member and practitioner discussion on treatment decisions.

SDM aids may focus on preference-sensitive conditions, chronic care management or lifestyle changes, to encourage patient commitment to self-care and treatment regimens.

The organization provides information (e.g., through the organization, practitioner, provider) about how, when, what conditions, and to whom certified SDM aids are offered. SDM aids must be certified by a third-party entity that evaluates quality. At least one SDM aid must be certified to meet the intent.

***Factor 3:* Practice transformation support**

Transformation includes movement to becoming a more-integrated or advanced practice (e.g., ACO, PCMH) and toward value-based care delivery.

The organization provides documentation that it supports practice transformation.

***Factor 4:* Comparative quality and cost information on selected specialties**

The organization provides comparative quality information about selected specialties to practitioners or providers and reports cost information if it is available. Comparative cost information may be cost or efficiency information and may be represented as relative rates or as a relative range.

Comparative quality information may be reported without cost information if cost information is not available.

To meet this requirement, the organization must provide quality information (with or without cost information) for at least one specialty and show that it has provided the information to at least one provider that refers members to the specialty.

***Factor 5:* Comparative pricing information for selected services**

Comparative pricing information may contain actual unit prices per service or relative prices per service, compared across practitioners or providers.

To meet this requirement, the organization must provide comparative pricing information on at least one service and show that it has provided the information to at least one provider that prescribes the service to members.

***Factor 6:* Another activity**

Other activities include those that cannot be categorized in factors 1–5. The organization describes the activity, how it supports providers or practitioners and how it contributes to achieving PHM goals.

Data sharing activities that use a different method of data sharing from that in factor 1 may be used to meet this factor. The method indicates how data are shared.

Exceptions

None.

Related information

Partners in Quality. The organization can receive automatic credit for factors 3 and 6 if the organization is an NCQA-designated Partner in Quality.

The organization must provide documentation of its status.

Examples

Factor 1

- Sharing patient-specific data listed below that the practitioner or provider does not have access to:
  - Pharmacy data.
  - ED reports.
  - Enrollment data.
  - Eligibility in the organization's intervention programs (e.g., enrollment in a wellness or complex case management program).
  - Reports on gaps in preventive services (e.g., a missed mammogram, need for a colonoscopy).
    - Claims data indicate if these services were not done; practitioners or staff can remind members to receive services.
  - Claims data.
  - Data generated by specialists, urgent clinics or other care providers.
- Methods of data sharing:
  - Transmitted through electronic channels as "raw" data to practitioners who conduct data analysis to drive improved patient outcomes.
  - Practitioner or provider portals that have accessible patient-specific data.
  - Submit data to a regional HIE.
- Reports created for practitioners or providers about patients or the attributed population.
  - A direct link to EHRs, to automatically populate recent claims for relevant information and alert practitioners or providers to changes in a patient's health status.

Factor 2

- Certification bodies:
  - National Quality Forum.
  - Washington State Health Care Authority.

Factor 3

- Incentive payments for PCMH arrangement.
- Technology support.
- Best practices.
- Supportive educational information, including webinars or other education sessions.
- Help with application fees for NCQA PCMH Recognition (beyond the NCQA program's sponsor discount).
- Help practices transform into a medical home.
- Provide incentives for NCQA PCMH Recognition, such as pay-for-performance.
- Use NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network.

Factor 4

- Selected specialties:
  - Specialties that a primary care practitioner refers members to most frequently.
- Quality information:
  - Organization-developed performance measures based on evidence-based guidelines.
    - AHRQ patient safety indicators associated with a provider.
    - In-patient quality indicators.
    - Risk-adjusted measures of mortality, complications and readmission.
  - Physician Quality Reporting System (PQRS) measures.
    - Non-PQRS Qualified Clinical Data Registry (QCDR) measures.
    - CAHPS measures.
    - The American Medical Association's Physician Consortium for Performance Improvement (PCPI) measures.
  - Cost information:
    - Relative cost of episode of care.
    - Relative cost of practitioner services.
    - In-office procedures.
  - Care pattern reports that include quality and cost information.

Factor 5

- Selected services:
  - Services for which the organization has unit price information.
  - Services commonly requested by primary care practitioners that are not conducted in-office.
  - Radiology services.
  - Outpatient procedures.
  - Pharmaceutical costs.

Factor 6

- Health plan staff located full-time at the provider facility to assist with member issues.
- The ability to view evidence-based practice guidelines on demand (e.g., practitioner portal).
- Incentives for two-way data sharing.

Element B: Value-Based Payment Arrangements—*Refer to Appendix 1 for points*

The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Scoring

100%	80%	50%	20%	0%
The organization demonstrates it has VBP arrangement(s) by reporting the percentage of payment tied to VBP	No scoring option	No scoring option	No scoring option	The organization does not demonstrate that it has VBP arrangement(s)

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For *First Surveys* and *Renewal Surveys*, NCQA reviews the VBP worksheet to demonstrate that it has VBP arrangements in each product line.

The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and *Renewal Surveys*: Prior to the survey date.

Explanation

This element may not be delegated.

There is broad consensus that payment models need to evolve from payment based on volume of services provided to models that consider value or outcomes. The FFS model does not adequately address the importance of non-visit-based care, care coordination and other functions that are proven to support achievement of population health goals.

The organization demonstrates that it has at least one VBP arrangement and reports the percentage of total payments made to providers and practitioners associated with each type of VBP arrangement.

The organization uses the following VBP types, sourced from *CMS* Reports *to Congress: Alternative Payment Models and Medicare Advantage* to report arrangements to NCQA. The organization is not required to use them for internal purposes. If the organization uses different labels for its VBP arrangements, it categorizes them using the NCQA provided definitions.

- **Pay-for-performance (P4P):** Payments are for individual units of service and triggered by care delivery, as under the FFS approach, but providers or practitioners can qualify for bonuses or be subject to penalties for cost and/or quality related performance. Foundational payments or payments for supplemental services also fall under this payment approach.
- **Shared savings:** Payments are FFS, but provider/practitioners who keep medical costs below the organization's established expectations retain a portion (up to 100 percent) of the savings generated. Providers/practitioners who qualify for a shared savings award must also meet standards for quality of care, which can influence the portion of total savings the provider or practitioner retains.
- **Shared risk:** Payments are FFS, but providers/practitioners whose medical costs are above expectations, as predetermined by the organization, are liable for a portion (up to 100 percent) of cost overruns.

- **Two-sided risk sharing:** Payments are FFS, but providers/practitioners agree to share cost overruns in exchange for the opportunity to receive shared savings.
- **Capitation/population-based payment:** Payments are not tied to delivery of services, but take the form of a fixed per patient, per unit of time sum paid in advance to the provider/practitioner for delivery of a set of services (partial capitation) or all services (full or global capitation). The provider/practitioner assumes partial or full risk for costs above the capitation/ population-based payment amount and retains all (or most) savings if costs fall below the capitation/population-based payment amount. Payments, penalties and awards depend on quality of care.

Calculating VBP reach

Percentage of payments is calculated by:

- (Numerator:) Total payments made to network practitioners/providers in contracts tied to VBP arrangement(s), divided by,
- (Denominator:) Total payments made to all network providers/practitioners in all contracts, including traditional FFS.

The percentage of payments can reflect the current year to date or the previous year's payments, and can be based on allowed amounts, actual payments or forecasted payments.

Types of providers/practitioners

For each type of VBP arrangement, the organization reports a percentage of total payments and indicates the provider/practitioner types included in the arrangement.

Exceptions

None.

Examples

None.

PHM 4: Wellness and Prevention—*Refer to Appendix 1 for points*

The organization offers wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk.

Intent

The organization helps members identify and manage health risks through evidence-based tools that maintain member privacy and explain how the organization uses collected information.

Summary of Changes

Additions

- Added factor 14 (Safety behaviors), added explanation text and updated the 100% scoring to reflect the new factor (Element C).

Clarifications

- Revised standard stem and intent statement.
- Added an exception for the Medicaid product line (Elements A–G).
- Clarified the explanation under the subhead for *Factor 5: Special needs assessment* to state that questions include specific demographics to meet the requirement (Element A).
- Clarified the explanation under the subhead for factor 2 to include requirements for the HA disclosure (Element B).

Element A: Health Appraisal Components—*Refer to Appendix 1 for points*

The organization's HA includes the following information:

1. **Questions on demographics.**
2. **Questions on health history, including chronic illness and current treatment.**
3. **Questions on self-perceived health status.**
4. **Questions to identify effective behavioral change strategies.**
5. **Questions to identify members with special hearing and vision needs and language preference.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA that is available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

HAs help identify at-risk and high-risk members, determine focus areas for timely intervention and prevention efforts and monitor risk change over time. They are an educational tool that can engage members in making healthy behavior changes.

The questions required by the factors gather information to determine members' overall risk or wellness, allowing the organization to tailor services and activities.

***Factor 1:* Demographics**

Member demographics include age, gender and ethnicity.

***Factor 2:* Personal health history**

No additional explanation required.

***Factor 3:* Self-perceived health status**

Self-perceived health status is a members' assessment of current health status and well-being.

***Factor 4:* Behavioral change strategies**

The HA includes questions to help guide changes in behavior and reduce risk.

***Factor 5:* Special needs assessment**

The HA includes questions that assess hearing and vision impairment and language preferences to help the organization provide special services, materials or equipment to members as needed. To meet this factor, questions must include all three special needs: hearing, vision impairment and language preferences.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

***Factor 1:* Demographics**

- Age.
- Gender.
- Race or ethnicity.
- Level of education.
- Level of income.
- Marital status.
- Number of children.

Factor 2: **Personal health history**

- Do you have any of the following conditions?
- Have you had any of the following conditions?
- Do you smoke or use tobacco? How long has it been since you smoked or used tobacco?
- When did you last receive the following preventive services or screenings?

Factor 3: **Self-perceived health status**

- SF 20® questions or other questions where participants rate their health status on a relative scale.

Factor 4: **Behavioral change theories and models**

- Prochaska's Stages of Change.
- Patient Activation Measure.
- Knowledge-Attitude Behavior Model.
- Health Belief Model.
- Theory of Reasoned Action.
- Bandura's Social Cognitive Theory.

Factor 5: **Special needs assessment**

- Do you have a vision impairment that requires special reading materials?
- Do you have a hearing impairment that requires special equipment?
- Is English your primary language? If not, what language do you prefer to speak?

Element B: Health Appraisal Disclosure—*Refer to Appendix 1 for points*

The organization's HA includes the following information in easy-to-understand language:

1. **How the information obtained from the HA will be used.**
2. **A list of organizations and individuals who might receive the information, and why.**
3. **A statement that participants may consent or decline to have information used and disclosed.**
4. **How the organization assesses member understanding of the language used to meet factors 1–3.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA for factors 1–3 and reviews policies and procedures for factor 4. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen

shots, supplemented with documents specifying the required features and functions of the site.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

***Factor 1:* Use of HA information**

No additional explanation required.

***Factor 2:* Information recipients**

A list of the organizations and individuals who will receive the information, and why, is required. Organizations and individuals are identified by role and are not required to be identified by name.

***Factor 3:* Right to consent or decline**

The HA may include a statement that the member accepts or declines participation or a notice that completion and submission implies consent to the HA's stated use. If the opportunity to consent or decline is associated with HA completion, members have access to the organization's definition of "HA completion." For online consent forms, disclosure information is available in printed form.

***Factor 4:* Assessing member understanding**

The HA is not expected to have language regarding how the organization assesses member understanding of HA disclosure requirements. NCQA reviews the organization's documented process for assessing member understanding.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

***Factor 2:* Information recipients**

- An organization that contracts directly with an employer or plan sponsor may disclose information to the participant's health plan. Because the employer or plan sponsor could change health plans, the organization may identify that it "disclose[s] information to the participant's health plan," instead of identifying the plan by name.
- An organization that has a direct relationship with practitioners may disclose information to a participant's primary care practitioner. Because the participant might change practitioners, the organization may identify that it "disclose[s] information to the member's primary care physician," instead of identifying the practitioner by name.

Element C: Health Appraisal Scope—*Refer to Appendix 1 for points*

HAs provided by the organization assess at least the following personal health characteristics and behaviors:

1. **Weight.**
2. **Height.**
3. **Smoking and tobacco use.**
4. **Physical activity.**
5. **Healthy eating.**
6. **Stress.**
7. **Productivity or absenteeism.**
8. **Breast cancer screening.**
9. **Colorectal cancer screening.**
10. **Cervical cancer screening.**
11. **Influenza vaccination.**
12. **At-risk drinking.**
13. **Depressive symptoms.**
14. **Safety behaviors.**

Scoring

100%	80%	50%	20%	0%
The organization meets 13-14 factors	The organization meets 11-12 factors	The organization meets 7-10 factors	The organization meets 3-6 factors	The organization meets 0-2 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA that is available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization offers an HA with questions that address the scope of areas evaluated by this element, even if no employers or plan sponsors purchase an HA that addresses the full scope listed in the factors.

Factors 1–13

No additional explanation required.

***Factor 14:* Safety behaviors**

Safety behaviors include, but are not limited to, wearing protective gear when recommended or wearing seat belts in motor vehicles. Evidence may not reveal a consistent set of validated questions, but safety behavior is closely associated with other modifiable risk areas, where validated questions exist.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Validated survey items. Evidence shows that certain HA items produce valid and reliable results for key health characteristics and behaviors listed in the factors. NCQA recommends that organizations use validated survey items on their HAs. Refer to the *Technical Specifications for Wellness & Health Promotion* publication for suggested validated survey items. The specifications are available through the *Publications and Products* section of the NCQA website.

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

***Factor 7:* Productivity or absenteeism**

- Work days missed due to personal or family health issues.
- Time spent on personal or family health issues during the work day.

Element D: Health Appraisal Results—*Refer to Appendix 1 for points*

Participants receive their HA results, which include the following information in language that is easy to understand:

1. **An overall summary of the participant's risk or wellness profile.**
2. **A clinical summary report describing individual risk factors.**
3. **Information on how to reduce risk by changing specific health behaviors.**
4. **Reference information that can help the participant understand the HA results.**
5. **A comparison to the individual's previous results, if applicable.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for evaluating the understandability of HA results and reviews HA results.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot

provide a test or demo log-on, NCQA reviews the organization's website or screen shots of web functionality, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

For factors 2–5, NCQA also reviews HA results for evidence that they contain all the health characteristics and behaviors listed in Element C.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meanings, to the extent practical.

***Factor 1:* Overall summary of risk and wellness profile**

HA results include:

- An evidenced-based summary or profile of the participant's overall level of risk or wellness.
- The core health areas (healthy weight [BMI] maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, clinical preventive services).

***Factor 2:* Clinical summary report**

A clinical summary report describes the risk factors that the HA identifies and is in a format that can be shared with a participant's practitioner.

***Factor 3:* Reducing risk and changing behavior**

HA results identify specific behaviors that can lower each risk factor and include recommended targets for improvement and information on how to reduce risk.

***Factor 4:* Reference information**

HA results include additional resources or information external to the organization that participants can use to learn more about their specific health risks and behaviors to improve their health and well-being.

***Factor 5:* Comparing HA results**

If a participant previously completed an HA administered by the organization, the organization includes comparison information to the previous HA results in the current report.

Exceptions

Factor 5 is NA if the organization has not previously administered an HA.

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples None.

Element E: Health Appraisal Format—*Refer to Appendix 1 for points*

The organization makes HAs available in language that is easy to understand, in the following formats:

1. **Digital services.**
2. **In print or by telephone.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for evaluating understandability, digital HA, and printed or telephonic HA. Each format must be in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization is capable of making HAs available through digital media, printed copies or telephone, even if no employers or plan sponsors purchase HAs in multiple formats.

Easy to understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

***Factor 1:* Digital services**

Digital services include online, Internet-based access and downloadable applications for smartphones and other devices.

***Factor 2:* In print or by telephone**

The printed version of the HA contains the same content as the web version of the HA.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples None.

Element F: Frequency of Health Appraisal Completion—*Refer to Appendix 1 for points*

The organization has the capability to administer the HA annually.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for administering annual HAs, or documentation that the organization administered an annual HA.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

Evidence of capability to administer

- Contracts that specify at least annual administration of the HA.
- Reports that demonstrate at least annual administration of the HA.

Element G: Health Appraisal Review and Update Process —*Refer to Appendix 1 for points*

The organization reviews and updates the HA every two years, and more frequently if new evidence is available.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for reviewing and updating its HA. The policies and procedures must be in place throughout the look-back period.

For Renewal Surveys, NCQA also reviews evidence that the organization reviewed and updated the HA every two years or more frequently if new evidence is available that warrants an update.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

No explanation required.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

Evidence of review

- Analysis of HA against current or new evidence.
- Documentation in meeting minutes or reports demonstrating review and update of the HA occurred.

Element H: Topics of Self-Management Tools—*Refer to Appendix 1 for points*

The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas:

1. **Healthy weight (BMI) maintenance.**
2. **Smoking and tobacco use cessation.**
3. **Encouraging physical activity.**
4. **Healthy eating.**
5. **Managing stress.**
6. **Avoiding at-risk drinking.**
7. **Identifying depressive symptoms.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for developing evidence based self-management tools, and reviews the organization's self-management tools. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities required by this element, even if it does not provide services to any employer or plan sponsor.

Self-management tools

Self-management tools help members determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk. They are interactive resources that allow members to enter specific personal information and provide immediate, individual results based on the information. This element addresses self-management tools that members can access directly from the organization's website or through other methods (e.g., printed materials, health coaches).

Evidence-based information

The organization meets the requirement of "evidenced-based" information if recognized sources are cited prominently in the self-management tools.

If the organization's materials do not cite recognized sources, NCQA also reviews the organization's documented process detailing the sources used, and how they were used in developing the self-management tools.

Factors 1–7

No additional explanation required.

Exceptions

None.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples

Self-management tools

- Interactive quizzes.
- Worksheets that can be personalized.
- Online logs of physical activity.
- Caloric intake diary.
- Mood log.

Element I: Usability Testing of Self-Management Tools—*Refer to Appendix 1 for points*

For each of the required seven health areas in Element H, the organization evaluates its self-management tools for usefulness to members at least every 36 months, with consideration of the following:

1. **Language is easy to understand.**
2. **Members' special needs, including vision and hearing, are addressed.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures, and reviews evidence of usability testing for each of the seven health areas. The score for the element is the average of the scores for all health areas.

Look-back period

For First Surveys and Renewal Surveys: At least once during the prior 36 months.

Explanation

Usability

The organization is not required to conduct usability testing with an external audience. Testing with internal staff who were not involved in development of the self-management tool meets the requirements of this element, if staff are representative of the population that will use the tool.

Factor 1: Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

Factor 2: Members with special needs

The organization's documented process explains the methods used to identify usability issues for members with special needs and the organization assesses its tools for members who have vision or hearing limitations. All must be addressed in order to receive credit for this factor.

Exception

Factors marked "No" in Element A are scored NA in this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples

Guidelines on usability testing for online tools

- www.usability.gov.

Evaluation methods

- Focus groups.
- Cognitive testing and surveys that focus on specific tools.

Element J: Review and Update Process for Self-Management Tools
—Refer to Appendix 1 for points

The organization demonstrates that it reviews its self-management tools on the following seven health areas and updates them every two years, or more frequently if new evidence is available:

1. **Healthy weight (BMI) maintenance.**
2. **Smoking and tobacco use cessation.**
3. **Encouraging physical activity.**
4. **Healthy eating.**
5. **Managing stress.**
6. **Avoiding at-risk drinking.**
7. **Identifying depressive symptoms.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

For Renewal Surveys, NCQA also reviews documentation that shows review and update of the self-management tools.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

Factors 1–7

No explanation required.

Exception

Factors marked "No" in Element A are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples

None.

Element K: Self-Management Tool Formats—*Refer to Appendix 1 for points*

The organization's self-management tools are offered in the following formats for each required seven health areas:

1. **Digital services.**
2. **In print or by telephone.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA scores this element for each of seven required health areas in Element H. The score for the element is the average of the scores for all health areas.

NCQA reviews the organization's digital and printed or telephonic self-management tools in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The content of self-management tools is the same in all formats.

***Factor 1:* Digital services**

Digital services include online, Internet-based access and downloadable applications for smartphones and other devices.

***Factor 2:* In print or by telephone**

Materials must be available in printed format or by telephone. An option to print an online document does not meet the requirement.

Exception

Factors marked "No" in Element H are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples

None.

PHM 5: Complex Case Management—*Refer to Appendix 1 for points*

The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources.

Intent

The organization helps members with multiple or complex conditions to obtain access to care and services, and coordinates their care.

Summary of Changes

Additions

- Combined former factor 1 (Health information line referral), factor 2 (DM program referral), factor 4 (UM referral) to the new factor 1 (Medical management program referral), updated scoring and added Explanation text for that factor (Element A).

Clarifications

- Clarified the standard statement to specify that highest-risk members are included in the CCM program.
- Replaced “psychosocial issues” with “social determinants of health” in factor 5 and revised the explanation text for that factor (Element C).
- Clarified the scope of review to state “files are selected from active or closed cases that were open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management” (Elements D, E).
- Updated the factor 5 language to state “initial assessment of social determinants of health” and revised the explanation text (Element D).
- Updated timeliness of assessment to state that the organization's initial assessment begins within 30 calendar days of identification and is completed within 60 days of identification (Element D).
- Added a fourth bullet under the subhead *Timeliness of assessment:* “The member is dead” (Element D).
- Added an example: *Factors 1–5: Case Management—Ongoing Management* (Element E).
- Added a bullet under the subhead for *Factor 1: Analyzing member feedback* in the explanation (Element F).

Element A: Access to Case Management—*Refer to Appendix 1 for points*

The organization has multiple avenues for members to be considered for complex case management services, including:

1. **Medical management program referral.**
2. **Discharge planner referral.**
3. **Member or caregiver referral.**
4. **Practitioner referral.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews evidence that the organization has multiple referral avenues in place throughout the look-back period and that it communicates the referral options to members and practitioners at least once during the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The overall goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

NCQA considers complex case management to be an opt-out program: All eligible members have the right to participate or to decline to participate.

The organization offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in the organization's DM program.

In addition to the process described in PHM 2, Element D: Segmentation, multiple referral avenues can minimize the time between identification of a need and delivery of complex case management services.

The organization has a process for facilitating referrals listed in the factors, even if it does not currently have access to the source.

Factor 1

Medical management program referrals include referrals that come from other organization programs or through a vendor or delegate. These may include disease management programs, UM programs, health information lines or similar programs that can identify needs for complex case management and are managed by organization or vendor staff.

Factor 2

No additional explanation required.

Factors 3, 4

The organization communicates referral options to members (factor 3) and practitioners (factor 4).

Exceptions

None.

Examples

Facilitating referrals

- Correspondence from members, caregivers or practitioners about potential eligibility.
- Monthly or quarterly reports, from various sources, of the number of members identified for complex case management.
- Brochures or mailings to referral sources about the complex case management program and instructions for making referrals.
- Web-based materials with information about the case management program and instructions for making referrals.

Element B: Case Management Systems—*Refer to Appendix 1 for points*

The organization uses case management systems that support:

1. **Evidence-based clinical guidelines or algorithms to conduct assessment and management.**
2. **Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred.**
3. **Automated prompts for follow-up, as required by the case management plan.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's complex case management system or annotated screenshots of system functionality. The system must be in place throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

***Factor 1:* Evidence-based clinical guidelines or algorithms**

The organization develops its complex case management system through one of the following sources:

- Clinical guidelines, ***or***
- Algorithms, ***or***
- Other evidence-based materials.

NCQA does not require the entire evidence-based guideline or algorithm to be imbedded in the automated system, but the components used to conduct assessment and management of patients must be imbedded in the system.

***Factor 2:* Automated documentation**

The complex case management system includes automated features that provide accurate documentation for each entry (record of actions or interaction with members, practitioners or providers) and use automatic date, time and user (user ID or name) stamps.

***Factor 3:* Automated prompts**

The complex case management system includes prompts and reminders for next steps or follow-up care.

Exceptions

None.

Examples

None.

Element C: Case Management Process—*Refer to Appendix 1 for points*

The organization's complex case management procedures address the following:

1. **Initial assessment of members' health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living.**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Initial assessment of life-planning activities.**
7. **Evaluation of cultural and linguistic needs, preferences or limitations.**
8. **Evaluation of visual and hearing needs, preferences or limitations.**
9. **Evaluation of caregiver resources and involvement.**
10. **Evaluation of available benefits.**
11. **Evaluation of community resources.**
12. **Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan.**
13. **Identification of barriers to member meeting goals or complying with the case management plan.**
14. **Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals.**

15. **Development of a schedule for follow-up and communication with members.**
16. **Development and communication of a member self-management plan.**
17. **A process to assess member progress against the case management plan.**

Scoring

100%	80%	50%	20%	0%
The organization meets 16-17 factors	The organization meets 12-15 factors	The organization meets 8-11 factors	The organization meets 3-7 factors	The organization meets 0-2 factors

Data source

Documented process

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This is a **structural requirement.** The organization must present its own documentation.

Complex case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases). The organization records the specific factor and the reason in the case management system and file.

Assessment and evaluation

Assessment and evaluation each require the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Factor 1: **Initial assessment of members' health status**

Complex case management policies and procedures specify the process for initial assessment of health status, specific to an identified condition and likely comorbidities (e.g., high-risk pregnancy and heart disease, for members with diabetes). The assessment should includes:

- Screening for presence or absence of comorbidities and their current status.
- Member's self-reported health status.
- Information on the event or diagnosis that led to the member's identification for complex case management.

Factor 2: **Documentation of clinical history**

Complex case management policies and procedures specify the process for documenting clinical history (e.g., disease onset; acute phases; inpatient stays; treatment history; current and past medications, including schedules and dosages).

Factor 3: **Initial assessment of activities of daily living**

Complex case management policies and procedures specify the process for assessing functional status related to activities of daily living, such as eating, bathing and mobility.

Factor 4: **Initial assessment of behavioral health status**

Complex case management policies and procedures specify the process for assessing behavioral health status, including:

- Cognitive functions:
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

Factor 5: **Initial assessment of social determinants of health**

Complex case management policies and procedures specify the process for assessing social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.

Factor 6: **Initial assessment of life-planning activities**

Complex case management policies and procedures specify the process for assessing whether members have completed life-planning activities such as wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms.

If a member does not have expressed life-planning instructions on record, during the first contact the case manager determines if life-planning instructions are appropriate. If they are not, the case manager records the reason in the member's file.

Providing life-planning information (e.g., brochure, pamphlet) to all members in case management meets the intent of this factor.

Factor 7: **Evaluation of cultural and linguistic needs**

Complex case management policies and procedures specify a process for assessing culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. It should include consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Factor 8: **Evaluation of visual and hearing needs**

Complex case management policies and procedures specify a process for assessing vision and hearing to identify potential barriers to effective communication or care.

Factor 9: **Evaluation of caregiver resources**

Complex case management policies and procedures specify a process for assessing the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation.

Factor 10: **Evaluation of available benefits**

Complex case management policies and procedures specify a process for assessing the adequacy of health benefits regarding the ability to fulfill a treatment plan. Assessment includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

***Factor 11:* Evaluation of community resources**

Complex case management policies and procedures specify a process for assessing eligibility for community resources that supplement those for which the organization has been contracted to provide, at a minimum:

- Community mental health.
- Transportation.
- Wellness organizations.
- Palliative care programs.

***Factor 12:* Individual case management plan and goals**

Complex case management policies and procedures specify a process for creating a personalized case management plan that meets member needs and includes:

- Prioritized goals.
  - Prioritized goals consider member and caregiver needs and preferences; they may be documented in any order, as long as the level of priority is clear.
- Time frame for reevaluation of goals.
- Resources to be utilized, including appropriate level of care.
- Planning for continuity of care, including transition of care and transfers between settings.
- Collaborative approaches to be used, including level of family participation.
  - Time frames for reevaluation are specified in the case management plan.

***Factor 13:* Identification of barriers**

Complex case management policies and procedures to a member receiving or participating in a case management plan. A barrier analysis can assess:

- Language or literacy level.
- Access to reliable transportation.
- Understanding of a condition.
- Motivation.
- Financial or insurance issues.
- Cultural or spiritual beliefs.
- Visual or hearing impairment.
- Psychological impairment.

The organization documents that it assessed barriers, even if none were identified.

***Factor 14:* Referrals to available resources**

Complex case management policies and procedures specify a process for facilitating referral to other health organizations, when appropriate.

***Factor 15:* Follow-up schedule**

Case management policies and procedures have a follow-up process that includes determining if follow-up is appropriate or necessary (for example, after a member is referred to a disease management program or health resource). The case management plan contains a schedule for follow-up that includes, but is not limited to:

- Counseling.
- Follow-up after referral to a DM program.
- Follow-up after referral to a health resource.
- Member education.

- Self-management support.
- Determining when follow-up is not appropriate.

Factor 16: **Development and communication of self-management plans**

Complex case management policies and procedures specify a process for communicating the self-management plan to the member or caregiver (i.e., verbally, in writing). **Self-management plans** are activities that help members manage a condition and are based on instructions or materials provided to them or to their caregivers.

Factor 17: **Assessing progress**

Complex case management policies and procedures specify a process for assessing progress toward overcoming barriers to care and to meeting treatment goals, and for assessing and adjusting the care plan and its goals, as needed.

Exceptions

None.

Examples

Factor 3: **Activities of daily living**

- Grooming.
- Dressing.
- Bathing.
- Toileting.
- Eating.
- Transferring (e.g., getting in and out of chairs).
- Walking.

Factor 4: **Cognitive functioning assessment**

- Alert/oriented, able to focus and shift attention, comprehends and recalls direction independently.
- Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situation (e.g. on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

Factor 5: **Social determinants of health**

- Current housing and housing security.
- Access to local food markets.
- Exposure to crime, violence and social disorder.
- Residential segregation and other forms of discrimination.
- Access to mass media and emerging technologies.
- Social support, norms and attitudes.
- Access, transportation and financial barriers to obtaining treatment.

***Factor 7:* Cultural needs, preferences or limitations**

- Health care treatments or procedures that are discouraged or not allowed for religious or spiritual reasons.
- Family traditions related to illness, death and dying.
- Health literacy assessment.

***Factor 9:* Caregiver assessment**

- Member is independent and does not need caregiver assistance.
- Caregiver currently provides assistance.
- Caregiver needs training, supportive services.
- Caregiver is not likely to provide assistance.
- Unclear if caregiver will provide assistance.
- Assistance needed but no caregiver available.

***Factor 10:* Assessment of available benefits**

- Benefits covered by the organization and by providers.
- Services carved out by the purchaser.
- Services that supplement those the organization has been contracted to provide, such as:
  - Community mental health.
  - Medicaid.
  - Medicare.
  - Long-term care and support.
  - Disease management organizations.
  - Palliative care programs.

***Factor 14:* Assessment of barriers[2]**

- Does the member understand the condition and treatment?
- Does the member want to participate in the case management plan?
- Does the member believe that participation will improve health?
- Are there financial or transportation limitations that may hinder the member from participating in care?
- Does the member have the mental and physical capacity to participate in care?

***Factor 16:* Self-management**

- Self-management includes ensuring that the member can:
  - Perform activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding).
  - Perform instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances).
  - Self-administer medication (e.g., oral, inhaled or injectable).
  - Self-administer medical procedures/treatments (e.g., change wound dressing).
  - Manage equipment (e.g., oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies).
  - Maintain a prescribed diet.
  - Chart daily weight, blood sugar.

[2]Lorig, K. 2001. *Patient Education, A Practical Approach.* Sage Publications, Thousand Oaks, CA. 186–92.

Element D: Initial Assessment—*Refer to Appendix 1 for points*

An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for:

1. **Initial assessment of member health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living (ADL).**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Evaluation of cultural and linguistic needs, preferences or limitations.**
7. **Evaluation of visual and hearing needs, preferences or limitations.**
8. **Evaluation of caregiver resources and involvement.**
9. **Evaluation of available benefits.**
10. **Evaluation of available community resources.**
11. **Assessment of life-planning activities.**

Scoring

100%	80%	50%	20%	0%
High (90-100%) on file review for 10-11 factors and medium (60-89%) on no more than 1 factor	High (90-100%) on file review for at least 7 factors and medium (60-89%) on file review for the remainder	At least medium (60-89%) on file review for 11 factors	Low (0-59%) on file review for 1-6 factors	7 or more factors in the low range (0-59%)

Data source

Records or files

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Documentation to meet the factors includes evidence that the assessments were completed and documented results of each assessment. A checklist of assessments without documentation of results does not meet the requirement.

Assessment components may be completed by other members of the care team and with the assistance of the member's family or caregiver. Assessment results for each factor must be clearly documented in case management notes, even if a factor does not apply.

If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the patient's family or caregiver.

If case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment must be performed after discharge if the member is identified for case management.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Assessment and evaluation

Assessment and evaluation each require that the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Timeliness of assessment

The organization begins the initial assessment within 30 calendar days of identifying a member for complex case management and completes it within 60 calendar days of identification. NCQA scores each factor "No" for files of initial assessments completed 60 calendar days or more from member identification, unless the delay was due to circumstances beyond the organization's control:

- The member is hospitalized during the initial assessment period.
- The member cannot be contacted or reached through telephone, letter, e-mail or fax.
- Natural disaster.
- The member is dead.

The organization documents the reasons for the delay and actions it has taken to complete the assessment.

The assessment may be derived from care or encounters occurring up to 30 calendar days prior to determining identification, if the information is related to the current episode of care (e.g., health history taken as part of disease management or during a hospitalization).

Files excluded from review

The organization excludes files from review that meet the following criteria:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - E-mail.
  - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA confirms that the files met the criteria for an NA score.

Factor 1: **Initial assessment of members' health status**

The file or case record documents a case manager's assessment of the member's current health status, including:

- Information on presence or absence of comorbidities and their current status.
- Self-reported health status.
- Information on the event or diagnosis that led to identification for complex case management.
- Current medications, including dosages and schedule.

Factor 2: **Documentation of clinical history**

The file or case record contains information on the member's clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Past medications, including schedules and dosages.

Factor 3: **Initial assessment of activities of daily living**

The file or case record documents a case manager's assessment of the member's functional status relative to at least the six basic ADLs. Bathing, hygiene, dressing, toileting, transferring or functional mobility and eating.

Factor 4: **Initial assessment of behavioral health status**

The file or case record documents a case manager's assessment of:

- Cognitive functions.
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

Factor 5: **Initial assessment of social determinants of health**

The case manager assesses social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet goals.

Factor 6: **Evaluation of cultural and linguistic needs**

The file or case record documents a case manager's evaluation of the member's culture and language needs and their impact on communication, care or acceptability of specific treatments. At a minimum, the case manager evaluates:

- Cultural health beliefs and practices.
- Preferred languages.
- Health literacy.

Factor 7: **Evaluation of visual and hearing needs**

The file or case record documents a case manager's evaluation of the member's vision and hearing. The document describes specific needs to consider in the case management plan and barriers to effective communication or care.

Factor 8: **Evaluation of caregiver resources**

The file or case record documents a case manager's evaluation of the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation. The documentation describes what resources are in place, whether these a sufficient for the members needs and notes specific gaps that should be addressed.

Factor 9: **Evaluation of available benefits**

The file or case record documents a case manager's evaluation of the adequacy of member's specific health insurance benefits in relation to the needs of the treatment plan. The evaluation goes beyond checking insurance coverage; it includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

Factor 10: **Evaluation of community resources**

The file or case record documents a case manager's evaluation of the member's eligibility for community resources and the availability of those resources. At a minimum, the evaluation includes:

- Community mental health.
- Transportation.
- Wellness programs.
- Nutritional support.
- Palliative care programs.

If a specific resource is not applicable to the member's situation, the case record or file documents why.

Factor 11: **Initial assessment of life planning activities**

The file or case record documents a case manager's assessment of whether the member has in place or has considered the need for wills, living wills or advance directives, Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms and health care powers of attorney.

During the first contact, the case manager assesses and documents whether it is appropriate to discuss these activities and documents with the member. If determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place.

If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Documentation that the organization provided life-planning information (e.g., brochure, pamphlet) to all members in complex case management meets the intent of this requirement.

Exceptions

None.

Examples

None.

Element E: Case Management—Ongoing Management—*Refer to Appendix 1 for points*

The NCQA review of a sample of the organization's complex case management files that demonstrates that the organization follows its documented processes for:

1. **Development of case management plans that include prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program.**
2. **Identification of barriers to meeting goals and complying with the case management plan.**
3. **Development of schedules for follow-up and communication with members.**
4. **Development and communication of member self-management plans.**
5. **Assessment of progress against case management plans and goals, and modification as needed.**

Scoring

100%	80%	50%	20%	0%
High (90%-100%) on file review for all 5 factors	High (90%-100%) on file review for at least 3 factors and low (0-59%) on 0 factors	At least medium (60-89%) on file review for 5 factors	Low (0-59%) on file review for no more than 2 factors	3 or more factors in the low range (0-59%)

Data source

Records or files

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Each case file contains evidence that the organization completed the five factors listed, according to its complex case management procedures specified in Element C.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Files excluded from review

The organization excludes files from review that meet these criteria:

- Identified members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - E-mail.
  - Fax.

- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA reserves the right to confirm that the files met the criteria for an NA score.

***Factor 1:* Case management plans and goals**

The organization documents a plan for case management that is specific to the member's situation and needs, and includes goals that reflect issues identified in the member assessment and the supporting rationale for goal selection. Goals are specific, measurable and timebound. To be timebound, each goal must have a target completion date. The organization prioritizes goals using high/low, numeric rank or other similar designation. Priorities reflect input from the member or a caregiver, demonstrating the member or caregiver's preferences and priorities.

***Factor 2:* Identification of barriers**

Barriers are related to the member or to the member's circumstances, not to the CCM process. The organization documents barriers to the member meeting the goals specified in the CCM plan.

***Factor 3:* Follow-up and communication with members**

The organization documents the next scheduled contact with the member, including the scheduled time or time frame and method, which may be an exact date or relative (e.g., "in two weeks").

***Factor 4:* Self-management plan**

A self-management plan includes actions the member agrees to take to manage a condition or circumstances. The organization documents that the plan has been communicated to the member. Communication may be verbal or written. Documentation includes the member's acknowledgment of and agreement to expected actions.

***Factor 5:* Assessment of progress**

The organization documents the member's progress toward goals. If the member does not demonstrate progress over time, the organization reassesses the applicability of the goals to the member's circumstances and modifies the goals, as appropriate.

Exceptions

None.

Examples ***Factors 1–5:*** **Case Management—Ongoing Management**

Member Diagnosis: Severe mental illness (depression); chronic homelessness (unstable housing for 8 months)	
Identification date: 1/5/2017	**Initial Assessment Completed:** 1/30/2017
Goal 1:	Secure stable housing for member by 2/11/2017. **(Factor 1**)
Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. **(Factor 1)** *Strategies to achieve goal:* Referral to community housing resources; secure temporary safe housing, pending a more permanent solution; accompany member to housing services. *Barriers to goal:* Member was previously evicted from temporary shelter due to unwillingness to comply with shelter staff rules. **(Factor 2)** *Progress assessment:* Member moved out of initial temporary shelter because he felt his belongings were unsafe. Asked for help getting into a home where he can lock up his belongings. CM adjusted completion date to 2/21/2017 and investigated group housing. **(Factor 5)**	
Goal 1 completed:	2/16/2017. ***Note:*** *Member was accepted into adult male group housing, once he understood and accepted house rules, is comfortable with secure locker for belongings.* **(Factor 5)**
Goal 2:	• Improve member's Patient Health Questionnaire-9 (PHQ-9) score from baseline (23 at initial assessment 1/30/2017) over 3–6 months. • Improve 5 points from baseline by 4/30/2017. • Improve 11 points from baseline by 7/30/2017. **(Factor 1)**
Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. Member feels that stable housing will help depression and is willing to attend therapy sessions. **(Factor 1)** *Strategies to achieve goal:* Implement a reminder system for taking medications; arrange transportation for therapist visits; check in weekly to discuss progress. *Barriers to goal:* Member uncertain about how to get to therapy sessions and states that he feels overwhelmed by having to change buses and remember schedules. Member said his medication has been stolen in shelters before. **(Factor 2)** *Progress assessment:* Member feels his medications are safe in group home lockers. CM helped the member set up a calendar pill case and clock alarm as medication reminders. CM arranged van transportation to twice weekly therapy sessions. CM assessed PHQ score at weekly call on 4/28/2017. Score was 16 (9 less than baseline). Member stated that housing greatly improved depression. Therapy sessions adjusted to weekly. CM assessed PHQ score at weekly call on 7/28/2017. Score was 12 (11 less than baseline). **(Factor 5)**	
Goal 2 completed:	7/28/2017. ***Note:*** *Member attends therapy. Member can navigate bus lines without anxiety; assisted transportation to sessions discontinued.* **(Factor 5)**
Follow-up and communication plan:	CM scheduled weekly follow-up calls at 5pm on Fridays via the group home's phone line. CM gave member direct emergency line and is working to secure cell phone for member. **(Factor 3)**

Self-management plan:	• Member will attend weekly follow-up calls on Fridays at 5pm via [number]. • Member will continue to follow rules of group home. • Member will alert CM if changes to housing occur. • Member will use alarm clock reminders to take medication on schedule. Member and CM will discuss monthly refills to medications box. • CM arranges medication to be mailed to group home; member agrees to verify medication with CM during weekly calls. • Member attends therapy sessions and alerts group home staff to dramatic changes in mood (e.g., suicidal ideation). • Member will work with group home staff and other residents to learn bus routes and how to change buses on route. **(Factor 4)** ***Note*:** *Member signed and has copies of the agreed-on self-management and case management plans. Signed copies attached.* **(Factor 4)**

Element F: Experience With Case Management—*Refer to Appendix 1 for points*

At least annually, the organization evaluates experience with its complex case management program by:

1. **Obtaining feedback from members.**
2. **Analyzing member complaints.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For *First Surveys,* NCQA reviews the organization's most recent annual data collection and evaluation report.

For *Renewal Surveys,* NCQA reviews the last two annual data collections and evaluation reports.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation

***Factor 1:* Analyzing member feedback**

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the complex case management programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may assess the entire population or draw statistically valid samples.

If the organization uses a sample, it describes the sample universe and the sampling methodology.

If satisfaction surveys are conducted at the corporate or regional level, results are stratified at the accreditable entity level for analysis and to determine actions. CAHPS and other general survey questions do not meet the intent of this element.

The organization conducts a quantitative data analysis to identify patterns in member feedback, and conducts a causal analysis if it did not meet stated goals.

Factor 2: **Analyzing member complaints**

The organization analyzes complaints to identify opportunities to improve satisfaction with its complex case management program.

Exceptions

None.

Examples

Member feedback questions

1. Did the case manager help you understand the treatment plan?
2. Did the case manager help you get the care you needed?
3. Did the case manager pay attention to you and help you with problems?
4. Did the case manager treat you with courtesy and respect?
5. How satisfied are you with the case management program?

Table 1: Annual complex case management member satisfaction survey results (N = Number of respondents)

How Satisfied Are You…	Very Satisfied		Satisfied		Combined		Sample Size	Percentage of Goal Met?
	N	%	N	%	N	%		
With how the case manager helped you understand the doctor's treatment plan?	75	60	25	20	100	80	125	No
With how the case manager helped you get the care you needed?	80	64	35	28	115	92	125	Yes
With the case manager's attention and help with problems?	70	56	45	36	1151	92	125	Yes
With how the case manager treated you?	85	68	35	28	120	96	125	Yes

The Complex Case Management Team and the QI staff conducted a root cause analysis of the areas where goals were not met.

Table 2: Member feedback qualitative analysis

Root Cause/Barrier	Opportunity for Improvement	Prioritized for Action (Y/N)
Members do not understand the treatment plan	Case managers identify health literacy issues and member preferences for information early in the case management process	Y

Complaints

- Limited access to case manager.
- Dissatisfaction with case manager.
- Timeliness of case management services.

Table 3: Complaint volume

Complex Case Management Complaints	Q1	Q2	Q3	Q4	Total 2017	Total 2016
Access to case manager	2	0	0	1	3	4
Dissatisfaction with case manager	1	2	0	1	4	5
Timeliness of case management services	1	0	2	2	5	5
Inquiries	3	1	2	4	10	12
Total case management	7	3	4	8	22	26

Findings

There were 22 complex case management complaints in 2018; there were 26 in 2017. Totals by category were also lower in 2018 than in 2017. Given the volume of cases over the past year, the numbers and types of complaints do not present opportunities for improvement.

The organization will continue to track and trend complaints and grievances annually, and compare results with the previous year's performance.

PHM 6: Population Health Management Impact *—Refer to Appendix 1 for points*

The organization measures the effectiveness of its PHM strategy.

Intent

The organization has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement.

Summary of Changes

Additions

- Added *PHM 6: Population Health Management Impact* as a new standard.

Element A: Measuring Effectiveness—*Refer to Appendix 1 for points*

At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:

1. **Quantitative results for relevant clinical, cost/utilization and experience measures.**
2. **Comparison of results with a benchmark or goal.**
3. **Interpretation of results.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First and Renewal Surveys, NCQA reviews the organization's plan for its annual comprehensive analysis of PHM strategy impact. Beginning on or after July 1, 2019, NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and Renewal Surveys: 6 months.

Explanation

This element is a **structural requirement.** The organization must present its own materials.

The organization conducts an annual quantitative analysis of findings.

***Factor 1:* Quantitative results**

Relevant measures align with the areas of focus, activities or programs as described in PHM 1, Element A. The organization describes why measures are relevant. Measures may focus on one segment of the population or on populations across the organization.

Clinical measures

Measures can be activities, events, occurrences or outcomes for which data can be collected for comparison with a threshold, benchmark or prior performance. There are two types of clinical measures:

1. *Outcome measures:* Incidence or prevalence rates for desirable or undesirable heath status outcomes (e.g., infant mortality).
2. *Process measures:* Measures of clinical performance based on objective clinical criteria defined from practice guidelines or other clinical specifications (e.g., immunization rates).

Cost/Utilization measures

Utilization is an unweighted count of services (e.g., inpatient discharges, inpatient days, office visits, prescriptions). Utilization measures capture the frequency of services provided by the organization. Cost-related measures can be used to demonstrate utilization. The organization measures cost, resource use or utilization.

Cost of care considers the mix and frequency of services, and is determined using actual unit price per service or unit prices found on a standardized fee schedule. Examples of cost of care measurement include:

- Dollars per episode, overall or by type of service.
- Dollars per member, per month (PMPM), overall or by type of service.
- Dollars per procedure.

Resource use considers the cost of services in addition to the count of services across the spectrum of care, such as the difference between a major surgery and a 15-minute office visit.

Experience

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the complex case management programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may also analyze complaints to identify opportunities to improve satisfaction.

The organization uses complex case management member experience results and member experience results from one other program or service.

CAHPS and other general survey questions do not meet the intent of this element.

Factor 2: Comparison of results

The organization performs a first-level, quantitative data analysis that compares results with an established, explicit and quantifiable goal or benchmark. Analysis includes past performance, if a previous measurement was performed.

Tests of statistical significance are not required, but may be useful when analyzing trends.

Factor 3: **Interpretation of results**

Interpretation of results gives the organization insight into its PHM programs and strategy, and helps it understand the programs' effectiveness and impact on areas of focus. The measures must be analyzed and assessed together to provide a comprehensive analysis of the effectiveness of the PHM strategy. The interpretation of the results should include interpretation of the measures and should go beyond just a presentation of the quantitative results of the measures. The organization conducts a qualitative analysis if stated goals are not met.

Note:

- *Participation rates do not qualify for this element.*
- *If the organization uses SF-8®, SF-12® or SF-36y to measure health status, results may count for two measures of effectiveness: one each for physical and mental health functioning.*

Exceptions

None.

Examples

Factor 1

Utilization includes measures of waste, overutilization, access, cost or underutilization.

Experience

- Patient Health Questionnaire (PHQ-9).
- Patient-Reported Outcomes Measurement Information System (PROMIS) tools.
- Program-specific surveys.

Element B: Improvement and Action—*Refer to Appendix 1 for points*

The organization uses results from the PHM impact analysis to annually:

1. **Identify opportunities for improvement.**
2. **Act on one opportunity for improvement.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First and Renewal Surveys, for surveys beginning on or after July 1, 2019, NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and Renewal Surveys: Prior to the survey date.

Explanation

This element is a **structural requirement.** The organization must present its own materials.

***Factor 1:* Opportunities for improvement**

The organization uses the results of its analysis to identify opportunities for improvement, which may be different each time data are measured and analyzed. NCQA does not prescribe a specific number of improvement opportunities.

***Factor 2:* Act on opportunity for improvement**

The organization develops a plan to act on at least one identified opportunity for improvement.

Exceptions

This element is NA for 2018.

Examples

None.

PHM 7: Delegation of PHM—*Refer to Appendix 1 for points*

If the organization delegates NCQA-required PHM activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated PHM activities.

Summary of Changes

Additions

- Added *PHM 7: Delegation of PHM* as a new standard.

Element A: Delegation Agreement—*Refer to Appendix 1 for points*

The written delegation agreement:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegated entity's performance.**
5. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect during the look-back period.

The delegation agreement describes all delegated PHM activities. A generic policy statement about the content of delegated arrangements does not meet this element.

***Factor 1:* Mutual agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

***Factor 2:* Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the PHM activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
- The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other PHM functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

***Factor 3:* Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about PHM delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited/Certified delegates.

***Factor 4:* Performance monitoring**

The delegation agreement specifies how the organization evaluates the delegate's performance.

***Factor 5:* Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples

None.

Element B: Provision of Member Data to the Delegate—*Refer to Appendix 1 for points*

The organization provides the following information to its delegates when requested:

1. **Member experience data, if applicable.**
2. **Clinical performance data.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews a sample of up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. NCQA reviews the organization's process for sharing information with its delegates.

For First Surveys and Renewal Surveys, NCQA also reviews evidence that the organization provides the delegate with direct access to or shared the information with its delegates when requested throughout the look-back period.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim and First Surveys: 6 months.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 12 months for all other PHM activities.

Explanation

This element may not be delegated.

If the organization delegates PHM activities, it allows the delegate to collect performance data necessary to assess member experience and clinical performance, as applicable. If the organization does not allow the delegate to collect data from members or practitioners directly, it provides data to the delegate to assess its performance.

NCQA scores this element "Yes" if the organization allows the delegate to collect performance data directly or provides data to the delegate.

***Factor 1:* Member experience data**

The organization provides data from complaints, CAHPS 5.0H survey results and other data collected on members' experience with the delegate's services.

***Factor 2:* Clinical performance data**

The organization provides data to the delegate on HEDIS measures, claims and other clinical data collected by the organization. The organization may provide data feeds for relevant claims data or provide results of relevant clinical performance measures.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples

None.

Element C: Provisions for PHI—*Refer to Appendix 1 for points*

If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions:

1. **A list of the allowed uses of PHI.**
2. **A description of delegate safeguards to protect the information from inappropriate use or further disclosure.**
3. **A stipulation that the delegate ensures that subdelegates have similar safeguards.**
4. **A stipulation that the delegate provides individuals with access to their PHI.**
5. **A stipulation that the delegate informs the organization if inappropriate use of the information occurs.**
6. **A stipulation that the delegate ensures that PHI is returned, destroyed or protected if the delegation agreement ends.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 6 factors	The organization meets 4-5 factors	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect within the look-back period.

***Factor 1:* Allowed uses of PHI**

The delegation agreement specifies PHI the delegate may use and disclose, and to whom PHI may be disclosed.

***Factors 2, 3:* Delegate and subdelegate safeguards**

The organization provides reasonable administrative, technical and physical safeguards to ensure PHI confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI.

***Factor 4:* Access to PHI**

No additional explanation required.

***Factor 5:* Inappropriate use of PHI**

The agreement specifies procedures for delegates to identify and report unauthorized access, use, disclosure, modification or destruction of PHI and the systems used to access or store PHI.

***Factor 6:* Disposal of PHI**

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements do not involve the use, creation or disclosure of PHI in any form.
- The agreement states that the delegation arrangement does not involve PHI.
- Delegation arrangements are with covered entities.

Examples None.

Element D: Predelegation Evaluation—*Refer to Appendix 1 for points*

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Scoring

100%	80%	50%	20%	0%
The organization evaluated delegate capacity before delegation began	No scoring option	The organization evaluated delegate capacity after delegation began	No scoring option	The organization did not evaluate delegate capacity

Data source Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's predelegation evaluation for up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim and First Surveys: 6 months.

For *Renewal Surveys*: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 12 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within the prescribed look-back periods prior to implementing delegation.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the prescribed look-back period, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional PHM activities less than 6 months or 12 months, as prescribed by the look-back period, prior to the survey date, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaborative. An organization may collaborate in a statewide, predelegation evaluation with other organizations that have overlapping practitioner and provider networks. The organizations in the collaborative use the same audit tool and share data.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element E: Review of PHM Program—*Refer to Appendix 1 for points*

For arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's PHM program.**
2. **Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.**
3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**
4. **Semiannually evaluates regular reports, as specified in Element A.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Reports

Scope of review

Factor 1 applies to Interim Surveys, First Surveys and Renewal Surveys.

All factors in this element apply to First Surveys and Renewal Surveys.

NCQA reviews a sample from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For *Interim Surveys*, NCQA reviews the organization's review of the delegate's PHM program.

For *First Surveys*, NCQA reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation.

For *Renewal Surveys*, NCQA reviews the organization's most recent and previous year's annual reviews, audits, performance evaluations and four semiannual evaluations

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 6 months for all other PHM activities.

For *Renewal Surveys*: Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA scores factor 2 and 3 "yes" if all delegates are NCQA NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

***Factor 1:* Review of the PHM program**

Appropriate organization staff or committee reviews the delegate's PHM program. At a minimum, the organization reviews parts of the PHM program that apply to the delegated functions.

***Factor 2:* Annual file audit**

If the organization delegates complex case management , it audits the delegate's complex case management files against NCQA standards. The organization uses either of the following to audit the files:

- 5 percent or 50 of its files, whichever is less.
- The NCQA "8/30 methodology" available at http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupportingDocuments.aspx

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

***Factor 3:* Annual evaluation**

No additional explanation required.

***Factor 4:* Evaluation of reports**

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is NA if the organization does not delegate complex case management activities.

Factors 2–4 are NA for Interim Surveys.

Examples

None.

Element F: Opportunities for Improvement—*Refer to Appendix 1 for points*

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Scoring

100%	80%	50%	20%	0%
At least once in each of the past 2 years that the delegation arrangement has been in effect, the organization has acted on identified problems, if any	No scoring option	The organization has taken inappropriate or weak action, or has taken action only in the past year	No scoring option	The organization has taken no action on identified problems

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews reports for opportunities for improvement if applicable from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For *First Surveys*, NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For *Renewal Surveys*, NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports, or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
  - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples

None.

Population Health Management

Standards for Population Health Management

PHM 1: PHM Strategy—*Refer to Appendix 1 for points*

The organization outlines its population health management (PHM) strategy for meeting the care needs of its member population.

Intent

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

Summary of Changes

Clarifications

- Added "in place throughout the look-back period" to the scope of review for documented process (Element A).
- Revised the look-back period for Renewal Surveys from 6 months to 12 months (Element A).
- Moved the Explanation text regarding the four areas of focus to the subsection *Factors 1, 2: Four areas of focus* to clarify that the language applies to factors 1 and 2 (Element A).
- Added an example regarding clinical safety to the subhead *Patient safety* in the examples for factors 1,2 (Element A).
- Added "materials" as a data source and revised the scope of review to remove the reference to July 1, 2019 (Element B).
- Revised the look-back period for Renewal Surveys to 6 months for materials and 12 months for documented process (Element B).

Element A: Strategy Description—*Refer to Appendix 1 for points*

The strategy describes:

1. Goals and populations targeted for each of the four areas of focus.*

2. Programs or services offered to members.

3. Activities that are not direct member interventions.

4. How member programs are coordinated.

5. How members are informed about available PHM programs.

***Critical factors: Score cannot exceed 20% if critical factors are not met.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews a description of the organization's comprehensive PHM strategy that is in place throughout the look-back period. The strategy may be fully described in one document or the organization may provide a summary document with references or links to supporting documents provided in other PHM elements.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

This element is a structural requirement. The organization must present its own materials.

Factor 1 is a critical factor that the organization must meet to score higher than 20% on this element.

***Factors 1, 2:* Four areas of focus**

The organization has a comprehensive strategy for population health management that, *at a minimum,* addresses member needs in the following four areas of focus:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.

At a minimum, the description includes the following for each of the four areas of focus:

- A goal (factor 1).
- A target population (factor 1).
- A program or service (factor 2).

Goals are measurable and specific to a target population. A program is a collection of services or activities to manage member health. A service is an activity or intervention in which individuals can participate to help reach a specified health goal.

***Factor 3:* Activities that are not direct member interventions**

The organization describes all activities it conducts in support of PHM programs or services not directed at individual members. An activity may apply to more than one areas of focus. The organization has at least one activity in place.

***Factor 4:* Coordination of member programs**

The organization coordinates programs or services it directs and those facilitated by providers, external management programs and other entities. The PHM strategy describes how the organization coordinates programs across settings, providers and levels of care to minimize the confusion for members being contacted from multiple sources. Coordination activities are not required to be exclusive to one area of focus and may apply across the continuum of care and to other organization initiatives.

***Factor 5:* Informing members**

The organization describes its process for informing members about all available PHM programs and services, regardless of level of contact. The organization may make the information available on its website; by mail, email, text or other mobile application; by telephone; or in person.

Exceptions

None.

Examples

***Factors 1, 2:* Goals, target populations, opportunities, programs or services**

Keeping members healthy

- Goal: 55 percent of members in the target population report receiving annual influenza vaccinations.
  - Target populations:
    - Members with no risk factors.
    - Members enrolled in wellness programs.
  - *Programs or services:* Community flu clinics, email and mail reminders, radio and TV advertisement reminding the public to get vaccinated.
- Goal:10 percent of the target population reports meeting a self-determined weight-loss goal.
  - *Target population:* Members with BMI 27 or above enrolled in wellness program.
  - *Programs or services:* Wellness program focusing on weight management.

Managing members with emerging risk

- Goal: Lower or maintain HbA1c control <8.0% rate by 2 percent compared to baseline.
  - Target population:
    - Members discovered to be at risk for diabetes during predictive analysis.
    - Members with controlled diabetes.
  - *Programs or services:* Diabetes management program.
- Goal: Improve asthma medication ratio (total rate) by 3 percent compared to baseline.
  - *Target population:* Diagnosed asthmatic members 18–64 years of age with at least one outpatient visit in the prior year.
  - *Programs or services:* Condition management program.

Patient safety

- Goal: Improve the safety of high-alert medications.
  - *Target population:* Members who are prescribed high-alert medications and receive home health care.
  - *Activity:* Collaborate with community-based organizations to complete medication reconciliation during home visits.
- Goal: Improve clinical safety.
  - *Target population:* Members receiving in-patient surgical procedures.
  - *Activity:* Distribute information to members that facilitates informed decisions regarding care such as:
    - Questions to ask surgeons before surgery.
    - Questions to ask the practitioner about medication interactions.
    - Resources needed at discharge such as appropriate nutrition or transportation assistance.
  - *Activity:* Implement follow-up system to contact members after discharge to confirm receipt of care and post-surgical care instructions.

Outcomes across settings

- Goal: Reduce 30-day readmission rate after hospital stay (all causes) of 3 days or more by 2 percentage points compared to baseline.
  - *Target population:* Members admitted through the emergency department who remain in the hospital for three days or more.
  - *Program or services:* Organization-based case manager conducts a follow-up interview post-stay to coordinate needed care.
  - *Activity:* Collaborate with network hospitals to develop and implement a discharge planning process.

Managing multiple chronic illnesses

- Goal: Reduce ED visits in target population by 3 percentage points in 12 months.
  - *Target population:* Members with uncontrolled diabetes and cardiac episodes that led to hospital stay of two days or more.
  - *Programs or services:* Complex case management.
- Goal: Improve antidepressant medication adherence rate.
  - *Target population:* Members with multiple behavioral health diagnoses, including severe depression, who lack access to behavioral health specialists.
  - *Programs or services:* Complex case management with behavioral health telehealth counseling component.

***Factor 3:* Activities that are not direct member interventions**

- Share data and information with practitioners.
- Interactions and integration with delivery systems (e.g., contract with accountable care organizations).
- Provide technology support to or integrate with patient-centered medical homes.
- Integrate with community resources.
- Value-based payment arrangements.
- Collaborate with community-based organizations and hospitals to improve transitions of care from the post-acute setting to the home.
- Collaborate with hospitals to improve patient safety.

Element B: Informing Members—*Refer to Appendix 1 for points*

The organization informs members eligible for programs that include interactive contact:

1. How members become eligible to participate.

2. How to use program services.

3. How to opt in or opt out of the program.

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For All Surveys: NCQA reviews the organization's policies and procedures in effect during the look-back period from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

For First Surveys and Renewal Surveys: NCQA also reviews materials sent to members from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

The score for the element is the average of the scores for all programs or services.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 6 months for materials; 12 months for documented process.

Explanation

This element applies to PHM programs or services in the PHM strategy that require interactive contact with members, including those offered directly by the organization.

Interactive contact

Programs with interactive contact have two-way interaction between the organization and the member, during which the member receives self-management support, health education or care coordination through one of the following methods:

- Telephone.
- In-person contact (i.e., individual or group).
- Online contact:
  - Interactive web-based module.
  - Live chat.
  - Secure email.
  - Video conference.

Interactive contact does not include:

- Completion of a health appraisal.
- Contacts made only to make an appointment, leave a message or verify receipt of materials.

Distribution of materials

The organization distributes information to members by mail, fax or email, or through messages to members' mobile devices, through real-time conversation or on its website, if it informs members that the information is available online. If the organization posts the information on its website, it notifies members that the information is available through another method listed above. The organization mails the information to members who do not have fax, email, telephone, mobile device or internet access. If the organization uses telephone or other verbal conversations, it provides a transcript of the conversation or script used to guide the conversation.

Factors 1–3: **Member information**

The organization provides eligible members with information on specific programs with interactive contact.

Exceptions

None.

Examples

Dear Member,

Because you had a recent hospital stay, you have been selected to participate in our Transitions Case Management Program. Sometime in the next three days, a nurse will call you to make sure you understand the instructions you were given when you left the hospital, and to make sure you have an appropriate provider to see for follow-up care.

To contact the nurse directly, call 555-555-1234. If you do not want to participate in the Transitions Case Management Program, let us know by calling 555-123-4567.

PHM 2: Population Identification—*Refer to Appendix 1 for points*

The organization systematically collects, integrates and assesses member data to inform its population health management programs.

Intent

The organization assesses the needs of its population and determines actionable categories for appropriate intervention.

Summary of Changes

Clarifications

- Revised the look-back period for First Surveys to 6 months and for Renewal Surveys to 12 months (Element A).
- Revised the first sentence of the Explanation for *Factor 1: Characteristics and needs* to state, "To determine the necessary structure and resources for its PHM program, the organization assesses the characteristics and needs of the member population" (Element B).
- Revised the look-back period for First and Renewal Surveys to state "at least once during the prior year" (Element C).
- Clarified the scope of review to state that NCQA reviews the most recent report for First Surveys and Renewal Surveys (Element D).
- Clarified the Explanation text under the subhead *Reports* to state that data may total more than 100 percent (Element D).

Element A: Data Integration—*Refer to Appendix 1 for points*

The organization integrates the following data to use for population health management functions:

1. Medical and behavioral claims or encounters.

2. Pharmacy claims.

3. Laboratory results.

4. Health appraisal results.

5. Electronic health records.

6. Health services programs within the organization.

7. Advanced data sources.

Scoring

100%	80%	50%	20%	0%
The organization meets 5-7 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures for the types and sources of integrated data.

For First and Renewal Surveys: NCQA reviews reports or materials (e.g., screenshots) for evidence that the organization integrated data types and data from sources listed in the factors. The organization may submit multiple examples that collectively demonstrate integration from all data types and sources, or may submit one example that demonstrates integration of all data types and sources.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Data integration is combining data from multiple sources databases. Data may be combined from multiple systems and sources (e.g., claims, pharmacy), across care sites (e.g., inpatient, ambulatory, home) and across domains (e.g., clinical, business, operational). The organization may limit data integration to the minimum necessary to identify eligible members and determine and support their care needs.

***Factor 1:* Claims or encounter data**

Requires both medical and behavioral claims or encounters. Behavioral claim data are not required if all purchasers of the organization's services carve out behavioral healthcare services (i.e., contract for a service or function to be performed by an entity other than the organization).

Factors 2, 3

No additional explanation required.

***Factor 4:* Health appraisals**

The organization demonstrates the capability to integrate data from health appraisals and health appraisals should be integrated if elected by plan sponsor.

***Factor 5:* Electronic health records**

Integrating EHR data from one practice or provider meets the intent of this requirement.

***Factor 6:* Health service programs within the organization.**

Relevant organization programs may include utilization management, care management or wellness coaching programs. The organization has a process for integrating relevant or necessary data from other programs to support identification of eligible members and determining care needs. Health appraisal results do not meet this factor.

***Factor 7:* Advanced data sources**

Advanced data sources aggregate data from multiple entities such as all-payer claims systems, regional health information exchanges and other community collaboratives. The organization must have access to the data to meet the intent of this factor.

Exceptions

None.

Examples

EHR integration

- Direct link from EHRs to data warehouse.
- Normalized data transfer or other method of transferring data from practitioner or provider EHRs.

Health services programs within the organization

- Case management.
- UM programs.
  - Daily hospital census data captured through UM.
  - Diagnosis and treatment options based on prior authorization data.
- Health information line.

Advanced data sources may require two-way data transfer. The organization and other entities can submit data to the source and can use data from the same source. These include but are not limited to:

- Regional, community or health system Health Information Exchanges (HIE).
- All-payer databases.
- Integrated data warehouses between providers, practitioners, and the organization with all parties contributing to and using data from the warehouse.
- State or regionwide immunization registries.

Element B: Population Assessment—*Refer to Appendix 1 for points*

The organization annually:

1. **Assesses the characteristics and needs, including social determinants of health, of its member population.**
2. **Identifies and assesses the needs of relevant member subpopulations.**
3. **Assesses the needs of child and adolescent members.**
4. **Assesses the needs of members with disabilities.**
5. **Assesses the needs of members with serious and persistent mental illness (SPMI).**

Scoring

100%	80%	50%	20%	0%
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys, NCQA reviews the organization's policies and procedures

For First and Renewal Surveys, NCQA reviews the organization's most recent annual assessment reports.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

The organization uses data at its disposal (e.g., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to identify the needs of its population.

***Factor 1:* Characteristics and needs**

To determine the necessary structure and resources for its PHM program, the organization assesses the characteristics and needs of the member population. The assessment includes the characteristics of the population and associated needs identified.

At a minimum, the organization assesses social determinants of health. Social determinants of health[1] are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. The organization defines the determinants assessed.

Characteristics that define a relevant population may also include, but are not limited to:

- Federal or state program eligibility (e.g., Medicare or Medicaid, SSI, dual-eligible).
- Multiple chronic conditions or severe injuries.
- At-risk ethnic, language or racial group.

***Factor 2:* Identifying and assessing characteristics and needs of subpopulations**

The organization uses the assessment of the member population to identify and assess relevant subpopulations.

***Factor 3:* Needs of children and adolescents**

The organization assesses the needs of members 2–19 years of age (children and adolescents). If the organization's regulatory agency's definition of children and adolescents is different from NCQA's, the organization uses the regulatory agency's definition. The organization provides the definition to NCQA, which determines whether the organization's needs assessment is consistent with the definition.

***Factors 4, 5:* Individuals with disabilities and SPMI**

Members with disabilities and with serious and persistent mental illness (SPMI) have particularly acute needs for care coordination and intense resource use (e.g., prevalence of chronic diseases).

Exception

Factor 3 is NA for the Medicare product line.

[1]https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Examples

***Factors 1, 2:* Relevant characteristics**

- Social determinants of health include:
  - Resources to meet daily needs.
  - Safe housing.
  - Local food markets.
  - Access to educational, economic and job opportunities.
  - Access to health care services.
  - Quality of education and job training.
  - Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
  - Transportation options.
  - Public safety.
  - Social support.
  - Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
  - Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community).
  - Socioeconomic conditions.
  - Residential segregation.
  - Language/literacy.
  - Access to mass media and emerging technologies.
  - Culture.
- Physical determinants include:
  - Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change).
  - Built environment, such as buildings, sidewalks, bike lanes and roads.
  - Worksites, schools and recreational settings.
  - Housing and community design.
  - Exposure to toxic substances and other physical hazards.
  - Physical barriers, especially for people with disabilities.
  - Aesthetic elements (e.g., good lighting, trees, benches).
  - Eligibility categories included in Medicaid managed care (e.g., TANF, low-income, SSI, other disabled).
  - Nature and extent of carved out benefits.
  - Type of Special Needs Plan (SNP) (e.g., dual eligible, institutional, chronic).
  - Race/ethnicity and language preference.

Element C: Activities and Resources—*Refer to Appendix 1 for points*

The organization annually uses the population assessment to:

1. **Review and update its PHM activities to address member needs.**
2. **Review and update its PHM resources to address member needs.**
3. **Review community resources for integration into program offerings to address member needs.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First and Renewal Surveys: NCQA reviews committee minutes or similar documents showing process and resource review and updates.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

***Factors 1, 2:* PHM activities and resources**

The organization uses assessment results to review and update its PHM structure, strategy (including programs, services, activities) and resources (e.g., staffing ratios, clinical qualifications, job training, external resource needs and contacts, cultural competency) to meet member needs.

***Factor 3:* Community resources**

The organization connects members with community resources or promotes community programs. Integrating community resources indicates that the organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population assessment.

Actively responding to member needs is more than posting a list of resources on the organization's website; active response includes referral services and helping members access community resources.

Exceptions

None.

Examples

Community resources and programs

- Population assessment determines a high population of elderly members without social supports. The organization partners with the Area Agency on Aging to help with transportation and meal delivery.
- Connect at-risk members with shelters.
- Connect food-insecure members with food security programs or sponsor community gardens.

- Sponsor or set up fresh food markets in communities lacking access to fresh produce.
- Participate as a community partner in healthy community planning.
- Partner with community organizations promoting healthy behavior learning opportunities (e.g., nutritional classes at local supermarkets, free fitness classes).
- Support community improvement activities by attending planning meetings or sponsoring improvement activities and efforts.
- Social workers or other community health workers that contact members to connect them with appropriate community resources.
- Referrals to community resources based on member need.
- Discounts to health clubs or fitness classes.

Element D: Segmentation—*Refer to Appendix 1 for points*

At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For All Surveys: NCQA reviews a description of the method used.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's most recent report demonstrating implementation.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

Population segmentation divides the population into meaningful subset using information collected through population assessment and other data sources.

Risk stratification uses the potential risk or risk status of individuals to assign them to tiers or subsets. Members in specific subsets may be eligible for programs or receive specific services.

Segmentation and risk stratification result in the categorization of individuals with care needs at all levels and intensities. Segmentation and risk stratification is a means of targeting resources and interventions to individuals who can most benefit from them. Either process may be used to meet this element.

Methodology

The organization describes its method for segmenting or stratifying its membership, including the subsets to which members are assigned (e.g., high-risk pregnancy, multiple inpatient admissions). The organization may use more than one risk stratification methods to determine actionable subsets.

Segmentation and stratification use population assessment and data integration findings (e.g., clinical and behavioral data, population and social needs) to determine subsets and programs or services for which members are eligible. Although these methods may include utilization/resource use or cost information. Methods that use only cost information for segmentation and stratification do not meet the intent of this element.

Reports

The organization provides reports specifying the number of members in each category and the programs or services for which they are eligible. Reports may be a "point-in-time" snapshot during the look-back period.

Reports reflect the number of members eligible for each PHM program. They display data in raw numbers and as a percentage of the total enrolled member population, and may total more than 100% if members fall into more than one category.

PHM programs or services provided to members include, but are not limited to, complex case management.

Exceptions

None.

Examples

Health Plan A: **Commercial HMO/PPO**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Pregnancy: Over 35 years, multiple gestation	High-risk pregnancy care management	55	0.5%
Type I Diabetes: Moderate risk	Diabetes management	660	6%
Tobacco use	Smoking cessation	110	1%
Behavioral health diagnosis in ages 15-19, rural	Telephone or video behavioral health counseling sessions	330	3%
Women of child-bearing age	Targeted women's health newsletter	3,850	35%
No risk factors	Routine member newsletters	2,750	25%
No associated data	None	3,850	35%

Health Plan A: **Medicare**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Multiple chronic conditions	Complex case management: Over 65	2,000	5%
Over 65, needs assistance with 2 or more ADLs	Long-term services and supports	2,800	7%
COPD: High risk	Complex case management: Over 65	1,600	4%
Osteoporosis: High-risk women	Targeted member newsletter	8,800	22%
BMI over 30	Weight management program	4,800	12%
No risk factors	Routine member newsletters	12,000	30%
No associated data	None	8,000	20%

PHM 3: Delivery System Supports—*Refer to Appendix 1 for points*

The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements.

Intent

The organization works with practitioners or providers to achieve population health management goals.

Summary of Changes

Clarifications

- Added "in place throughout the look-back period" to the scope of review for documented process (Element A).
- Revised the look-back period for Renewal Surveys from 6 months to 12 months (Element A).
- Moved the examples for *Factor 3: Providing practice transformation support to primary care practitioners* as the third paragraph under *Related information* (Element A).
- Revised the scoring language for 100% and 0% (Element B).
- Revised the look-back period for First Surveys to 6 months and Renewal Surveys to 12 months (Element B).

Element A: Practitioner or Provider Support—*Refer to Appendix 1 for points*

The organization supports practitioners or providers in its network to achieve population health management goals by:

1. Sharing data.

2. Offering evidence-based or certified decision-making aids.

3. Providing practice transformation support to primary care practitioners.

4. Providing comparative quality information on selected specialties.

5. Providing comparative pricing information on selected services.

6. One additional activity to support practitioners or providers in achieving PHM goals.

Scoring

100%	80%	50%	20%	0%
The organization meets 3-6 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's description of how it supports practitioners or providers.

For First Surveys and *Renewal Surveys:* NCQA reviews the organization's description that is in place throughout the look-back period of how it supports practitioners or providers and materials demonstrating implementation.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

The organization identifies and implements activities that support practitioners and providers in meeting population health goals. Practitioners and providers may include accountable care entities, primary or specialty practitioners, PCMHs, or other providers included in the organization's network. Organizations may determine the practitioners or providers they support.

***Factor 1:* Data sharing**

Data sharing is transmission of member data from the health plan to the provider or practitioner that assists in delivering services, programs, or care to the member. The organization determines the frequency for sharing data.

***Factor 2:* Evidence-based or certified decision-making aids**

Shared decision-making (SDM) aids provide information about treatment options and outcomes. SDM aids are designed to complement practitioner counselling, not replace it. SDM aids facilitate member and practitioner discussion on treatment decisions.

SDM aids may focus on preference-sensitive conditions, chronic care management or lifestyle changes, to encourage patient commitment to self-care and treatment regimens.

SDM aids are certified by a third party that evaluates quality, or are created using evidence-based criteria. If certified, the organization provides information about how, when, under what conditions and to whom certified SDM aids are offered. If created using evidence-based criteria, criteria must be cited. At least one certified or evidence-based SDM aid must be offered to meet the intent.

***Factor 3:* Practice transformation support**

Transformation includes movement to becoming a more-integrated or advanced practice (e.g., ACO, PCMH) and toward value-based care delivery.

The organization provides documentation that it supports practice transformation.

***Factor 4:* Comparative quality and cost information on selected specialties**

The organization provides comparative quality information about selected specialties to practitioners or providers and reports cost information if it is available. Comparative cost information may be cost or efficiency information and may be represented as relative rates or as a relative range.

Comparative quality information may be reported without cost information if cost information is not available.

To meet this requirement, the organization must provide quality information (with or without cost information) for at least one specialty and show that it has provided the information to at least one provider that refers members to the specialty.

***Factor 5:* Comparative pricing information for selected services**

Comparative pricing information may contain actual unit prices per service or relative prices per service, compared across practitioners or providers.

To meet this requirement, the organization must provide comparative pricing information on at least one service and show that it has provided the information to at least one provider that prescribes the service to members.

***Factor 6:* Another activity**

Other activities include those that cannot be categorized in factors 1–5. The organization describes the activity, how it supports providers or practitioners and how it contributes to achieving PHM goals.

Data sharing activities that use a different method of data sharing from that in factor 1 may be used to meet this factor. The method indicates how data are shared.

Exceptions

None.

Related information

Partners in Quality. The organization receives automatic credit for factors 3 and 6 if it is an NCQA-designated Partner in Quality.

The organization must provide documentation of its status.

Practice transformation support. The organization can support its practitioners/providers in meeting their population health management goals by any of the following methods:

- Incentive payments for PCMH arrangement.
- Technology support.
- Best practices.
- Supportive educational information, including webinars or other education sessions.
- Help with application fees for NCQA PCMH Recognition (beyond the NCQA program's sponsor discount).
- Help practices transform into a medical home.
- Provide incentives for NCQA PCMH Recognition, such as pay-for-performance.
- Use NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network.

Examples

Factor 1

- Sharing patient-specific data listed below that the practitioner or provider does not have access to:
  - Pharmacy data.
  - ED reports.
  - Enrollment data.
  - Eligibility in the organization's intervention programs (e.g., enrollment in a wellness or complex case management program).
  - Reports on gaps in preventive services (e.g., a missed mammogram, need for a colonoscopy).
    - Claims data indicate if these services were not done; practitioners or staff can remind members to receive services.
  - Claims data.
  - Data generated by specialists, urgent care clinics or other care providers.

- Methods of data sharing:
  - Transmitted through electronic channels as "raw" data to practitioners who conduct data analysis to drive improved patient outcomes.
  - Practitioner or provider portals that have accessible patient-specific data.
  - Submit data to a regional HIE.
  - Reports created for practitioners or providers about patients or the attributed population.
  - A direct link to EHRs, to automatically populate recent claims for relevant information and alert practitioners or providers to changes in a patient's health status.

Factor 2

- Certification bodies:
  - National Quality Forum.
  - Washington State Health Care Authority.

Factor 4

- Selected specialties:
  - Specialties that a primary care practitioner refers members to most frequently.
- Quality information:
  - Organization-developed performance measures based on evidence-based guidelines.
    - AHRQ patient safety indicators associated with a provider.
    - In-patient quality indicators.
    - Risk-adjusted measures of mortality, complications and readmission.
    - Physician Quality Reporting System (PQRS) measures.
    - Non-PQRS Qualified Clinical Data Registry (QCDR) measures.
    - CAHPS measures.
  - The American Medical Association's Physician Consortium for Performance Improvement (PCPI) measures.
  - Cost information:
    - Relative cost of episode of care.
    - Relative cost of practitioner services.
  - In-office procedures.
  - Care pattern reports that include quality and cost information.

Factor 5

- Selected services:
  - Services for which the organization has unit price information.
  - Services commonly requested by primary care practitioners that are not conducted in-office.
  - Radiology services.
  - Outpatient procedures.
  - Pharmaceutical costs.

Factor 6

- Health plan staff located full-time at the provider facility to assist with member issues.
- The ability to view evidence-based practice guidelines on demand (e.g., practitioner portal).
- Incentives for two-way data sharing.

Element B: Value-Based Payment Arrangements—*Refer to Appendix 1 for points*

The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First Surveys and Renewal Surveys: NCQA reviews the VBP worksheet to demonstrate that it has VBP arrangements in each product line.

The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 12 months.

Explanation

This element may not be delegated.

There is broad consensus that payment models need to evolve from payment based on volume of services provided to models that consider value or outcomes. The fee-for-service (FFS) model does not adequately address the importance of non-visit-based care, care coordination and other functions that are proven to support achievement of population health goals.

The organization demonstrates that it has at least one VBP arrangement and reports the percentage of total payments made to providers and practitioners associated with each type of VBP arrangement.

The organization uses the following VBP types, sourced from *CMS Report to Congress: Alternative Payment Models and Medicare Advantage* to report arrangements to NCQA. The organization is not required to use them for internal purposes. If the organization uses different labels for its VBP arrangements, it categorizes them using the NCQA provided definitions.

- *Pay-for-performance (P4P):* Payments are for individual units of service and triggered by care delivery, as under the FFS approach, but providers or practitioners can qualify for bonuses or be subject to penalties for cost and/or quality related performance. Foundational payments or payments for supplemental services also fall under this payment approach.
- *Shared savings:* Payments are FFS, but provider/practitioners who keep medical costs below the organization's established expectations retain a portion (up to 100 percent) of the savings generated. Providers/practitioners who qualify for a shared savings award must also meet standards for quality of care, which can influence the portion of total savings the provider or practitioner retains.
- *Shared risk:* Payments are FFS, but providers/practitioners whose medical costs are above expectations, as predetermined by the organization, are liable for a portion (up to 100 percent) of cost overruns.

- *Two-sided risk sharing:* Payments are FFS, but providers/practitioners agree to share cost overruns in exchange for the opportunity to receive shared savings.
- *Capitation/population-based payment:* Payments are not tied to delivery of services, but take the form of a fixed per patient, per unit of time sum paid in advance to the provider/practitioner for delivery of a set of services (partial capitation) or all services (full or global capitation). The provider/practitioner assumes partial or full risk for costs above the capitation/ population-based payment amount and retains all (or most) savings if costs fall below the capitation/population-based payment amount. Payments, penalties and awards depend on quality of care.

Calculating VBP reach

Percentage of payments is calculated by:

- *Numerator:* Total payments made to network practitioners/providers in contracts tied to VBP arrangement(s), divided by,
- *Denominator:* Total payments made to all network providers/practitioners in all contracts, including traditional FFS.

The percentage of payments can reflect the current year to date or the previous year's payments, and can be based on allowed amounts, actual payments or forecasted payments.

Types of providers/practitioners

For each type of VBP arrangement, the organization reports a percentage of total payments and indicates the provider/practitioner types included in the arrangement.

Exceptions

None.

Examples None.

PHM 4: Wellness and Prevention—*Refer to Appendix 1 for points*

The organization offers wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk.

Intent

The organization helps adult members identify and manage health risks through evidence-based tools that maintain member privacy and explain how the organization uses collected information.

Summary of Changes

Clarifications

- Revised the look-back period from 6 months to 12 months for Renewal Surveys, for factor 14 (Element C).
- Added "throughout the look-back period" to the scope of review for documented process (Elements I, J).
- Clarified in the Explanation for *Factor 2: Members with special needs* that vision and hearing must be addressed to receive credit for the factor (Element I).

Element A: Health Appraisal Components—*Refer to Appendix 1 for points*

The organization's HA includes the following information:

1. **Questions on demographics.**
2. **Questions on health history, including chronic illness and current treatment.**
3. **Questions on self-perceived health status.**
4. **Questions to identify effective behavioral change strategies.**
5. **Questions to identify members with special hearing and vision needs and language preference.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA that is available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

HAs help identify at-risk and high-risk members, determine focus areas for timely intervention and prevention efforts and monitor risk change over time. They are an educational tool that can engage members in making healthy behavior changes.

The questions required by the factors gather information to determine members' overall risk or wellness, allowing the organization to tailor services and activities.

***Factor 1:* Demographics**

Member demographics include age, gender and ethnicity.

***Factor 2:* Personal health history**

No additional explanation required.

***Factor 3:* Self-perceived health status**

Self-perceived health status is a members' assessment of current health status and well-being.

***Factor 4:* Behavioral change strategies**

The HA includes questions to help guide changes in behavior and reduce risk.

***Factor 5:* Special needs assessment**

The HA includes questions that assess hearing and vision impairment and language preferences to help the organization provide special services, materials or equipment to members as needed. To meet this factor, questions must include all three special needs: hearing, vision impairment and language preferences.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

***Factor 1:* Demographics**

- Age.
- Gender.
- Race or ethnicity.
- Level of education.
- Level of income.
- Marital status.
- Number of children.

Factor 2: **Personal health history**

- Do you have any of the following conditions?
- Have you had any of the following conditions?
- Do you smoke or use tobacco? How long has it been since you smoked or used tobacco?
- When did you last receive the following preventive services or screenings?

Factor 3: **Self-perceived health status**

- SF 20® questions or other questions where participants rate their health status on a relative scale.

Factor 4: **Behavioral change theories and models**

- Prochaska's Stages of Change.
- Patient Activation Measure.
- Knowledge-Attitude Behavior Model.
- Health Belief Model.
- Theory of Reasoned Action.
- Bandura's Social Cognitive Theory.

Factor 5: **Special needs assessment**

- Do you have a vision impairment that requires special reading materials?
- Do you have a hearing impairment that requires special equipment?
- Is English your primary language? If not, what language do you prefer to speak?

Element B: Health Appraisal Disclosure—*Refer to Appendix 1 for points*

The organization's HA includes the following information in easy-to-understand language:

1. **How the information obtained from the HA will be used.**
2. **A list of organizations and individuals who might receive the information, and why.**
3. **A statement that participants may consent or decline to have information used and disclosed.**
4. **How the organization assesses member understanding of the language used to meet factors 1–3.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's HA for factors 1–3 and reviews policies and procedures for factor 4. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

***Factor 1:* Use of HA information**

No additional explanation required.

***Factor 2:* Information recipients**

A list of the organizations and individuals who will receive the information, and why, is required. Organizations and individuals are identified by role and are not required to be identified by name.

***Factor 3:* Right to consent or decline**

The HA may include a statement that the member accepts or declines participation or a notice that completion and submission implies consent to the HA's stated use. If the opportunity to consent or decline is associated with HA completion, members have access to the organization's definition of "HA completion." For online consent forms, disclosure information is available in printed form.

***Factor 4:* Assessing member understanding**

The HA is not expected to have language regarding how the organization assesses member understanding of HA disclosure requirements. NCQA reviews the organization's documented process for assessing member understanding.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

***Factor 2:* Information recipients**

- An organization that contracts directly with an employer or plan sponsor may disclose information to the participant's health plan. Because the employer or plan sponsor could change health plans, the organization may identify that it "disclose[s] information to the participant's health plan," instead of identifying the plan by name.
- An organization that has a direct relationship with practitioners may disclose information to a participant's primary care practitioner. Because the participant might change practitioners, the organization may identify that it "disclose[s] information to the member's primary care physician," instead of identifying the practitioner by name.

Element C: Health Appraisal Scope—*Refer to Appendix 1 for points*

HAs provided by the organization assess at least the following personal health characteristics and behaviors:

1. **Weight.**
2. **Height.**
3. **Smoking and tobacco use.**
4. **Physical activity.**
5. **Healthy eating.**
6. **Stress.**
7. **Productivity or absenteeism.**
8. **Breast cancer screening.**
9. **Colorectal cancer screening.**
10. **Cervical cancer screening.**
11. **Influenza vaccination.**
12. **At-risk drinking.**
13. **Depressive symptoms.**
14. **Safety behaviors.**

Scoring

100%	80%	50%	20%	0%
The organization meets 13-14 factors	The organization meets 11-12 factors	The organization meets 7-10 factors	The organization meets 3-6 factors	The organization meets 0-2 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA that is available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen

shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months; 12 months for factor 14.

Explanation

The organization offers an HA with questions that address the scope of areas evaluated by this element, even if no employers or plan sponsors purchase an HA that addresses the full scope listed in the factors.

Factors 1–13

No additional explanation required.

***Factor 14:* Safety behaviors**

Safety behaviors include, but are not limited to, wearing protective gear when recommended or wearing seat belts in motor vehicles. Evidence may not reveal a consistent set of validated questions, but safety behavior is closely associated with other modifiable risk areas, where validated questions exist.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Validated survey items. Evidence shows that certain HA items produce valid and reliable results for key health characteristics and behaviors listed in the factors. NCQA recommends that organizations use validated survey items on their HAs. Refer to the *Technical Specifications for Wellness & Health Promotion* publication for suggested validated survey items. The specifications are available through the *Publications and Products* section of the NCQA website.

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

***Factor 7:* Productivity or absenteeism**

- Work days missed due to personal or family health issues.
- Time spent on personal or family health issues during the work day.

Element D: Health Appraisal Results—*Refer to Appendix 1 for points*

Participants receive their HA results, which include the following information in language that is easy to understand:

1. An overall summary of the participant's risk or wellness profile.

2. A clinical summary report describing individual risk factors.

3. Information on how to reduce risk by changing specific health behaviors.

4. Reference information that can help the participant understand the HA results.

5. A comparison to the individual's previous results, if applicable.

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for evaluating the understandability of HA results and reviews HA results.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots of web functionality, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

For factors 2–5, NCQA also reviews HA results for evidence that they contain all the health characteristics and behaviors listed in Element C.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meanings, to the extent practical.

***Factor 1:* Overall summary of risk and wellness profile**

HA results include:

- An evidenced-based summary or profile of the participant's overall level of risk or wellness.
- The core health areas (healthy weight [BMI] maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, clinical preventive services).

Factor 2: **Clinical summary report**

A clinical summary report describes the risk factors that the HA identifies and is in a format that can be shared with a participant's practitioner.

Factor 3: **Reducing risk and changing behavior**

HA results identify specific behaviors that can lower each risk factor and include recommended targets for improvement and information on how to reduce risk.

Factor 4: **Reference information**

HA results include additional resources or information external to the organization that participants can use to learn more about their specific health risks and behaviors to improve their health and well-being.

Factor 5: **Comparing HA results**

If a participant previously completed an HA administered by the organization, the organization includes comparison information to the previous HA results in the current report.

Exceptions

Factor 5 is NA if the organization has not previously administered an HA.

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples None.

Element E: Health Appraisal Format—*Refer to Appendix 1 for points*

The organization makes HAs available in language that is easy to understand, in the following formats:

1. Digital services.

2. In print or by telephone.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for evaluating understandability, digital HA and printed or telephonic HA. Each format must be in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization is capable of making HAs available through digital media, printed copies or telephone, even if no employers or plan sponsors purchase HAs in multiple formats.

Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

***Factor 1:* Digital services**

Digital services include online, internet-based access and downloadable applications for smartphones and other devices.

***Factor 2:* In print or by telephone**

The printed version of the HA contains the same content as the web version of the HA.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

None.

Element F: Frequency of Health Appraisal Completion—*Refer to Appendix 1 for points*

The organization has the capability to administer the HA annually.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for administering annual HAs, or documentation that the organization administered an annual HA.

Look-back period

For First Surveys: At least once during the prior year.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Evidence of capability to administer

- Contracts that specify at least annual administration of the HA.
- Reports that demonstrate at least annual administration of the HA.

Element G: Health Appraisal Review and Update Process —*Refer to Appendix 1 for points*

The organization reviews and updates the HA every two years, and more frequently if new evidence is available.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for reviewing and updating its HA. The policies and procedures must be in place throughout the look-back period.

For Renewal Surveys: NCQA also reviews evidence that the organization reviewed and updated the HA every two years or more frequently if new evidence is available that warrants an update.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

No explanation required.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Evidence of review

- Analysis of HA against current or new evidence.
- Documentation in meeting minutes or reports demonstrating review and update of the HA occurred.

Element H: Topics of Self-Management Tools—*Refer to Appendix 1 for points*

The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas:

1. Healthy weight (BMI) maintenance.

2. Smoking and tobacco use cessation.

3. Encouraging physical activity.

4. Healthy eating.

5. Managing stress.

6. Avoiding at-risk drinking.

7. Identifying depressive symptoms.

Scoring

100%	80%	50%	20%	0%
The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for developing evidence based self-management tools, and reviews the organization's self-management tools. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities required by this element, even if it does not provide services to any employer or plan sponsor.

Self-management tools

Self-management tools help members determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk. They are interactive resources that allow members to enter specific personal information and provide immediate, individual results based on the information. This element addresses self-management tools that members can access directly from the organization's website or through other methods (e.g., printed materials, health coaches).

Evidence-based information

The organization meets the requirement of "evidenced-based" information if recognized sources are cited prominently in the self-management tools.

If the organization's materials do not cite recognized sources, NCQA also reviews the organization's documented process detailing the sources used, and how they were used in developing the self-management tools.

Factors 1–7

No additional explanation required.

Exceptions

None.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Self-management tools

- Interactive quizzes.
- Worksheets that can be personalized.
- Online logs of physical activity.
- Caloric intake diary.
- Mood log.

Element I: Usability Testing of Self-Management Tools—*Refer to Appendix 1 for points*

For each of the required seven health areas in Element H, the organization evaluates its self-management tools for usefulness to members at least every 36 months, with consideration of the following:

1. Language is easy to understand.

2. Members' special needs, including vision and hearing, are addressed.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures in place throughout the look-back period, and reviews evidence of usability testing for each of the seven health areas. The score for the element is the average of the scores for all health areas.

Look-back period

For First Surveys and Renewal Surveys: At least once during the prior 36 months.

Explanation

Usability

The organization is not required to conduct usability testing with an external audience. Testing with internal staff who were not involved in development of the self-management tool meets the requirements of this element, if staff are representative of the population that will use the tool.

Factor 1: Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

Factor 2: Members with special needs

The organization's documented process explains the methods used to identify usability issues for members with special needs. Vision and hearing must be addressed to receive credit for this factor.

Exception

Factors marked "No" in Element H are scored NA in this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Guidelines on usability testing for online tools

- www.usability.gov.

Evaluation methods

- Focus groups.
- Cognitive testing and surveys that focus on specific tools.

Element J: Review and Update Process for Self-Management Tools
—Refer to Appendix 1 for points

The organization demonstrates that it reviews its self-management tools on the following seven health areas and updates them every two years, or more frequently if new evidence is available:

1. Healthy weight (BMI) maintenance.

2. Smoking and tobacco use cessation.

3. Encouraging physical activity.

4. Healthy eating.

5. Managing stress.

6. Avoiding at-risk drinking.

7. Identifying depressive symptoms.

Scoring

100%	80%	50%	20%	0%
The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures in place throughout the look-back period.

For Renewal Surveys: NCQA also reviews documentation that shows review and update of the self-management tools.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

Factors 1–7

No explanation required.

Exception

Factors marked "No" in Element H are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

None.

Element K: Self-Management Tool Formats—*Refer to Appendix 1 for points*

The organization's self-management tools are offered in the following formats for each of the required seven health areas:

1. Digital services.

2. In print or by telephone.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA scores this element for each of seven required health areas in Element H. The score for the element is the average of the scores for all health areas.

NCQA reviews the organization's digital and printed or telephonic self-management tools in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The content of self-management tools is the same in all formats.

***Factor 1:* Digital services**

Digital services include online, internet-based access and downloadable applications for smartphones and other devices.

***Factor 2:* In print or by telephone**

Materials must be available in printed format or by telephone. An option to print an online document does not meet the requirement.

Exception

Factors marked "No" in Element H are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

None.

PHM 5: Complex Case Management—*Refer to Appendix 1 for points*

The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources.

Intent

The organization helps members with multiple or complex conditions to obtain access to care and services, and coordinates their care.

Summary of Changes

Clarifications

- Clarified the scope of review for First and Renewal Surveys to state that policies and procedures are in place throughout the look-back period (Element C).
- Revised the look-back period for Renewal Surveys from 6 months to 12 months for factors 3, 5 and 11 (Element C).
- Moved the second paragraph of the Explanation under the subhead *Assessment and evaluation* (Element C).
- Clarified under the subhead *Assessment and evaluation* that the policies describe the process to collect information and document summary (Element C).
- Clarified the explanation under *factor 5 (social determinants of health)* to state that the organization considers more than one social determinant of health (Elements C, D).
- Moved "Time frames are specified in the case management plan" to be a subbullet under *Time frames for reevaluation* in the Explanation for factor 12 (Element C).
- Revised the look-back period to 12 months for Renewal Surveys, for all factors (Element D).
- Divided the Explanation for *Factor 1: Case management plans and goals* into two paragraphs and added text to clarify that goals must be both timebound and prioritized (Element E).

Element A: Access to Case Management—*Refer to Appendix 1 for points*

The organization has multiple avenues for members to be considered for complex case management services, including:

1. Medical management program referral.

2. Discharge planner referral.

3. Member or caregiver referral.

4. Practitioner referral.

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews evidence that the organization has multiple referral avenues in place throughout the look-back period and that it communicates the referral options to members and practitioners at least once during the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The overall goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

NCQA considers complex case management to be an opt-out program: All eligible members have the right to participate or to decline to participate.

The organization offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in the organization's DM program.

In addition to the process described in PHM 2, Element D: Segmentation, multiple referral avenues can minimize the time between identification of a need and delivery of complex case management services.

The organization has a process for facilitating referrals listed in the factors, even if it does not currently have access to the source.

Factor 1

Medical management program referrals include referrals that come from other organization programs or through a vendor or delegate. These may include disease management programs, UM programs, health information lines or similar programs that can identify needs for complex case management and are managed by organization or vendor staff.

Factor 2

No additional explanation required.

Factors 3, 4

The organization communicates referral options to members (factor 3) and practitioners (factor 4).

Exceptions

None.

Examples

Facilitating referrals

- Correspondence from members, caregivers or practitioners about potential eligibility.
- Monthly or quarterly reports, from various sources, of the number of members identified for complex case management.

- Brochures or mailings to referral sources about the complex case management program and instructions for making referrals.
- Web-based materials with information about the case management program and instructions for making referrals.

Element B: Case Management Systems—*Refer to Appendix 1 for points*

The organization uses case management systems that support:

1. **Evidence-based clinical guidelines or algorithms to conduct assessment and management.**
2. **Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred.**
3. **Automated prompts for follow-up, as required by the case management plan.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's complex case management system or annotated screenshots of system functionality. The system must be in place throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.
For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

***Factor 1:* Evidence-based clinical guidelines or algorithms**

The organization develops its complex case management system through one of the following sources:

- Clinical guidelines, ***or***
- Algorithms, ***or***
- Other evidence-based materials.

NCQA does not require the entire evidence-based guideline or algorithm to be imbedded in the automated system, but the components used to conduct assessment and management of patients must be imbedded in the system.

***Factor 2:* Automated documentation**

The complex case management system includes automated features that provide accurate documentation for each entry (record of actions or interaction with members, practitioners or providers) and use automatic date, time and user (user ID or name) stamps.

Factor 3: **Automated prompts**

The complex case management system includes prompts and reminders for next steps or follow-up care.

Exceptions

None.

Examples None.

Element C: Case Management Process—*Refer to Appendix 1 for points*

The organization's complex case management procedures address the following:

1. **Initial assessment of member health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living.**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Initial assessment of life-planning activities.**
7. **Evaluation of cultural and linguistic needs, preferences or limitations.**
8. **Evaluation of visual and hearing needs, preferences or limitations.**
9. **Evaluation of caregiver resources and involvement.**
10. **Evaluation of available benefits.**
11. **Evaluation of community resources.**
12. **Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan.**
13. **Identification of barriers to the member meeting goals or complying with the case management plan.**
14. **Facilitation of member referrals to resources and a follow-up process to determine whether members act on referrals.**
15. **Development of a schedule for follow-up and communication with members.**
16. **Development and communication of a member self-management plan.**
17. **A process to assess member progress against the case management plan.**

Scoring

100%	80%	50%	20%	0%
The organization meets 16-17 factors	The organization meets 12-15 factors	The organization meets 8-11 factors	The organization meets 3-7 factors	The organization meets 0-2 factors

Data source Documented process

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA reviews the organization's policies and procedures in place throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months; 12 months for factors 3, 5 and 11.

Explanation

This is a structural requirement. The organization must present its own documentation.

Assessment and evaluation

Assessment and evaluation each require the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. Policies describe the process to both collect information and document a summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Complex case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases) and specify that the organization documents such assessment in the case management system and file.

***Factor 1:* Initial assessment of members' health status**

Complex case management policies and procedures specify the process for initial assessment of health status, specific to an identified condition and likely comorbidities (e.g., high-risk pregnancy and heart disease, for members with diabetes). The assessment includes:

- Screening for presence or absence of comorbidities and their current status.
- Member's self-reported health status.
- Information on the event or diagnosis that led to the member's identification for complex case management.

***Factor 2:* Documentation of clinical history**

Complex case management policies and procedures specify the process for documenting clinical history (e.g., disease onset; acute phases; inpatient stays; treatment history; current and past medications, including schedules and dosages).

***Factor 3:* Initial assessment of activities of daily living**

Complex case management policies and procedures specify the process for assessing functional status related to at least the six basic ADLs: bathing, dressing, going to the toilet, transferring, feeding and continence.

***Factor 4:* Initial assessment of behavioral health status**

Complex case management policies and procedures specify the process for assessing behavioral health status, including:

- Cognitive functions:
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.

- Mental health conditions.
- Substance use disorders.

Factor 5: **Initial assessment of social determinants of health**

Complex case management policies and procedures specify the process for assessing social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.

Because social determinants of health are a combination of influences, the organization considers more than one social determinant of health, for a comprehensive overview of the member's health.

Factor 6: **Initial assessment of life-planning activities**

Complex case management policies and procedures specify the process for assessing whether members have completed life-planning activities such as wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms.

If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Providing life-planning information (e.g., brochure, pamphlet) to all members in case management meets the intent of this factor.

Factor 7: **Evaluation of cultural and linguistic needs**

Complex case management policies and procedures specify a process for assessing culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. Policies and procedures also include consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Factor 8: **Evaluation of visual and hearing needs**

Complex case management policies and procedures specify a process for assessing vision and hearing to identify potential barriers to effective communication or care.

Factor 9: **Evaluation of caregiver resources**

Complex case management policies and procedures specify a process for assessing the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation.

Factor 10: **Evaluation of available benefits**

Complex case management policies and procedures specify a process for assessing the adequacy of health benefits regarding the ability to fulfill a treatment plan. Assessment includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

Factor 11: Evaluation of community resources

Complex case management policies and procedures specify a process for assessing eligibility for community resources that supplement those for which the organization has been contracted to provide, at a minimum:

- Community mental health.
- Transportation.
- Wellness organizations.
- Palliative care programs.
- Nutritional support.

Factor 12: Individual case management plan and goals

Complex case management policies and procedures specify a process for creating a personalized case management plan that meets member needs and includes:

- Prioritized goals.
  - Prioritized goals consider member and caregiver needs and preferences; they may be documented in any order, as long as the level of priority is clear.
- Time frames for reevaluation of goals.
  - Time frames are specified in the case management plan.
- Resources to be utilized, including appropriate level of care.
- Planning for continuity of care, including transition of care and transfers between settings.
- Collaborative approaches to be used, including level of family participation.

Factor 13: Identification of barriers

Complex case management policies and procedures to a member receiving or participating in a case management plan. A barrier analysis can assess:

- Language or literacy level.
- Access to reliable transportation.
- Understanding of a condition.
- Motivation.
- Financial or insurance issues.
- Cultural or spiritual beliefs.
- Visual or hearing impairment.
- Psychological impairment.

The organization documents that it assessed barriers, even if none were identified.

Factor 14: Referrals to available resources

Complex case management policies and procedures specify a process for facilitating referral to other health organizations, when appropriate.

Factor 15: Follow-up schedule

Case management policies and procedures have a follow-up process that includes determining if follow-up is appropriate or necessary (for example, after a member is referred to a disease management program or health resource). The case management plan contains a schedule for follow-up that includes, but is not limited to:

- Counseling.
- Follow-up after referral to a DM program.
- Follow-up after referral to a health resource.
- Member education.
- Self-management support.
- Determining when follow-up is not appropriate.

Factor 16: **Development and communication of self-management plans**

Complex case management policies and procedures specify a process for communicating the self-management plan to the member or caregiver (i.e., verbally, in writing). Self-management plans are activities that help members manage a condition and are based on instructions or materials provided to them or to their caregivers.

Factor 17: **Assessing progress**

Complex case management policies and procedures specify a process for assessing progress toward overcoming barriers to care and to meeting treatment goals, and for assessing and adjusting the care plan and its goals, as needed.

Exceptions

None.

Examples

Factor 3: **Activities of daily living**

- Grooming.
- Dressing.
- Bathing.
- Toileting.
- Eating.
- Transferring (e.g., getting in and out of chairs).
- Walking.

Factor 4: **Cognitive functioning assessment**

- Alert/oriented, able to focus and shift attention, comprehends and recalls direction independently.
- Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situation (e.g. on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

Factor 5: **Social determinants of health**

- Current housing and housing security.
- Access to local food markets.
- Exposure to crime, violence and social disorder.

- Residential segregation and other forms of discrimination.
- Access to mass media and emerging technologies.
- Social support, norms and attitudes.
- Access, transportation and financial barriers to obtaining treatment.

***Factor 7:* Cultural needs, preferences or limitations**

- Health care treatments or procedures that are discouraged or not allowed for religious or spiritual reasons.
- Family traditions related to illness, death and dying.
- Health literacy assessment.

***Factor 9:* Caregiver assessment**

- Member is independent and does not need caregiver assistance.
- Caregiver currently provides assistance.
- Caregiver needs training, supportive services.
- Caregiver is not likely to provide assistance.
- Unclear if caregiver will provide assistance.
- Assistance needed but no caregiver available.

***Factor 10:* Assessment of available benefits**

- Benefits covered by the organization and by providers.
- Services carved out by the purchaser.
- Services that supplement those the organization has been contracted to provide, such as:
  - Community mental health.
  - Medicaid.
  - Medicare.
  - Long-term care and support.
  - Disease management organizations.
  - Palliative care programs.

***Factor 13:* Assessment of barriers**[2]

- Does the member understand the condition and treatment?
- Does the member want to participate in the case management plan?
- Does the member believe that participation will improve health?
- Are there financial or transportation limitations that may hinder the member from participating in care?
- Does the member have the mental and physical capacity to participate in care?

***Factor 16:* Self-management**

- Self-management includes ensuring that the member can:
  - Perform activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding).
  - Perform instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances).

[2]Lorig, K. 2001. *Patient Education, A Practical Approach*. Thousand Oaks, CA: Sage Publications. 186–92.

- Self-administer medication (e.g., oral, inhaled or injectable).
- Self-administer medical procedures/treatments (e.g., change wound dressing).
- Manage equipment (e.g., oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies).
- Maintain a prescribed diet.
- Chart daily weight, blood sugar.

Element D: Initial Assessment—*Refer to Appendix 1 for points*

An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for:

1. **Initial assessment of member health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living (ADL).**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Evaluation of cultural and linguistic needs, preferences or limitations.**
7. **Evaluation of visual and hearing needs, preferences or limitations.**
8. **Evaluation of caregiver resources and involvement.**
9. **Evaluation of available benefits.**
10. **Evaluation of available community resources.**
11. **Assessment of life-planning activities.**

Scoring

100%	80%	50%	20%	0%
High (90-100%) on file review for 10-11 factors and medium (60-89%) on no more than 1 factor	High (90-100%) on file review for at least 7 factors and medium (60-89%) on file review for the remainder	At least medium (60-89%) on file review for 11 factors	Low (0-59%) on file review for 1-6 factors	7 or more factors in the low range (0-59%)

Data source

Records or files

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were opened during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 12 months.

Explanation

Documentation to meet the factors includes evidence that the assessments were completed and documented results of each assessment. A checklist of assessments without documentation of results does not meet the requirement.

Assessment components may be completed by other members of the care team and with the assistance of the member's family or caregiver. Assessment results for each factor must be clearly documented in case management notes, even if a factor does not apply.

If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the patient's family or caregiver.

If case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment must be performed after discharge if the member is identified for case management.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Assessment and evaluation

Assessment and evaluation each require that the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Timeliness of assessment

The organization begins the initial assessment within 30 calendar days of identifying a member for complex case management and completes it within 60 calendar days of identification. If the initial assessment was started after the first 30 calendar days of member identification, NCQA scores only factor 1 "No"; the remaining factors are not marked down for starting after the first 30 calendar days of identification.

Additionally, NCQA scores any factor for which the initial assessment is completed more than 60 calendar days from member identification "No", unless the delay was due to circumstances beyond the organization's control:

- The member is hospitalized during the initial assessment period.
- The member cannot be contacted or reached through telephone, letter, email or fax.
- Natural disaster.
- The member is deceased.

The organization documents the reasons for the delay and actions it has taken to complete the assessment.

The assessment may be derived from care or encounters occurring up to 30 calendar days prior to determining identification, if the information is related to the current episode of care (e.g., health history taken as part of disease management or during a hospitalization).

Members are considered eligible upon identification unless they subsequently opt out or additional information reveals them to be ineligible.

Excluded files from review

The organization excludes files from review that meet the following criteria:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - Email.
  - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA confirms that the files met the criteria for an NA score.

***Factor 1:* Initial assessment of members' health status**

The file or case record documents a case manager's assessment of the member's current health status, including:

- Information on presence or absence of comorbidities and their current status.
- Self-reported health status.
- Information on the event or diagnosis that led to identification for complex case management.
- Current medications, including dosages and schedule.

***Factor 2:* Documentation of clinical history**

The file or case record contains information on the member's clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Past medications, including schedules and dosages.

***Factor 3:* Initial assessment of activities of daily living**

The file or case record documents the results of the ADL assessment.

For ADLs with which the member needs assistance, the type of assistance and reason for need of assistance is recorded. The case manager does not need to describe ADLs the member does not need assistance with.

If the member does not need assistance with any ADLs, the case file or case notes reflect that no assistance is needed (e.g., "Member is fully independent with ADLs").

***Factor 4:* Initial assessment of behavioral health status**

The file or case record documents a case manager's assessment of:

- Cognitive functions.
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

***Factor 5:* Initial assessment of social determinants of health**

The case manager assesses social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet goals.

Because social determinants of health are a combination of influences, the organization considers more than one social determinant of health, for a comprehensive overview of the member's health.

***Factor 6:* Evaluation of cultural and linguistic needs**

The file or case record documents a case manager's evaluation of the member's culture and language needs and their impact on communication, care or acceptability of specific treatments. At a minimum, the case manager evaluates:

- Cultural health beliefs and practices.
- Preferred languages.

***Factor 7:* Evaluation of visual and hearing needs**

The file or case record documents a case manager's evaluation of the member's vision and hearing. The document describes specific needs to consider in the case management plan and barriers to effective communication or care.

***Factor 8:* Evaluation of caregiver resources**

The file or case record documents a case manager's evaluation of the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation. Documentation describes the resources in place and whether they are sufficient for the member's needs, and notes specific gaps to address.

***Factor 9:* Evaluation of available benefits**

The file or case record documents a case manager's evaluation of the adequacy of the member's health insurance benefits in relation to the needs of the treatment plan. The evaluation goes beyond checking insurance coverage; it includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

***Factor 10:* Evaluation of community resources**

The file or case record documents a case manager's evaluation of the member's eligibility for community resources and the availability of those resources and documents which the member may need.

For the community resources the member needs, the availability and member's eligibility is also recorded in the file. The case manager does not need to address community resources the member does not need.

If no community resources are needed by the member, the case file or case notes reflect that no community resources are needed (e.g., "Member does not need any of the available community resources").

Factor 11: **Initial assessment of life planning activities**

The file or case record documents a case manager's assessment of whether the member has in place or has considered the need for wills, living wills or advance directives, Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms and health care powers of attorney.

If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Documentation that the organization provided life-planning information (e.g., brochure, pamphlet) to all members in complex case management meets the intent of this requirement.

Exceptions

None.

Examples None.

Element E: Case Management: Ongoing Management—*Refer to Appendix 1 for points*

The NCQA review of a sample of the organization's complex case management files that demonstrates that the organization follows its documented processes for:

1. **Development of case management plans that include prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program.**
2. **Identification of barriers to meeting goals and complying with the case management plan.**
3. **Development of schedules for follow-up and communication with members.**
4. **Development and communication of member self-management plans.**
5. **Assessment of progress against case management plans and goals, and modification as needed.**

Scoring

100%	80%	50%	20%	0%
High (90%-100%) on file review for all 5 factors	High (90%-100%) on file review for at least 3 factors and low (0-59%) on 0 factors	At least medium (60-89%) on file review for 5 factors	Low (0-59%) on file review for no more than 2 factors	3 or more factors in the low range (0-59%)

Data source Records or files

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were opened during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 12 months.

Explanation

Each case file contains evidence that the organization completed the five factors listed, according to its complex case management procedures specified in Element C.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Excluded files from review

The organization excludes files from review that meet these criteria:

- Identified members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - Email.
  - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA reserves the right to confirm that the files met the criteria for an NA score.

***Factor 1:* Case management plans and goals**

The organization documents a plan for case management that is specific to the member's situation and needs, and includes goals that reflect issues identified in the member assessment and the supporting rationale for goal selection. Goals are specific, measurable and timebound. To be timebound, each goal must have a target completion date.

Case management goals are prioritized. The organization prioritizes goals using high/low, numeric rank or other similar designation. Priorities reflect input from the member or a caregiver, demonstrating the member or caregiver's preferences and priorities. Designating goals as long-term or short-term is not sufficient to meet the requirement. The organization must rank or prioritize goals.

***Factor 2:* Identification of barriers**

Barriers are related to the member or to the member's circumstances, not to the CCM process. The organization documents barriers to the member meeting the goals specified in the CCM plan.

***Factor 3:* Follow-up and communication with members**

The organization documents the next scheduled contact with the member, including the scheduled time or time frame and method, which may be an exact date or relative (e.g., "in two weeks").

***Factor 4:* Self-management plan**

A self-management plan includes actions the member agrees to take to manage a condition or circumstances. The organization documents that the plan has been communicated to the member. Communication may be verbal or written. Documentation includes the member's acknowledgment of and agreement to expected actions.

***Factor 5:* Assessment of progress**

The organization documents the member's progress toward goals. If the member does not demonstrate progress over time, the organization reassesses the applicability of the goals to the member's circumstances and modifies the goals, as appropriate.

Exceptions

None.

Examples ***Factors 1–5:* Case Management—Ongoing Management**

<table>
<tr><td colspan="2">Member Diagnosis: Severe mental illness (depression); chronic homelessness (unstable housing for 8 months)</td></tr>
<tr><td>Identification date: 1/5/2018</td><td>Initial Assessment Completed: 1/30/2018</td></tr>
<tr><td>Goal 1:</td><td>Secure stable housing for member by 2/11/2018. (Factor 1)</td></tr>
<tr><td colspan="2">Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. (Factor 1)

Strategies to achieve goal: Referral to community housing resources; secure temporary safe housing, pending a more permanent solution; accompany member to housing services.

Barriers to goal: Member was previously evicted from temporary shelter due to unwillingness to comply with shelter staff rules. (Factor 2)

Progress assessment: Member moved out of initial temporary shelter because he felt his belongings were unsafe. Asked for help getting into a home where he can lock up his belongings. CM adjusted completion date to 2/21/2018 and investigated group housing. (Factor 5)</td></tr>
<tr><td>Goal 1 completed:</td><td>2/16/2018.
Note: Member was accepted into adult male group housing, once he understood and accepted house rules, is comfortable with secure locker for belongings. (Factor 5)</td></tr>
</table>

Goal 2:	• Improve member's Patient Health Questionnaire-9 (PHQ-9) score from baseline (23 at initial assessment 1/30/2018) over 3–6 months. • Improve 5 points from baseline by 4/30/2018. • Improve 11 points from baseline by 7/30/2018. **(Factor 1)**
Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. Member feels that stable housing will help depression and is willing to attend therapy sessions. **(Factor 1)** *Strategies to achieve goal:* Implement a reminder system for taking medications; arrange transportation for therapist visits; check in weekly to discuss progress. *Barriers to goal:* Member uncertain about how to get to therapy sessions and states that he feels overwhelmed by having to change buses and remember schedules. Member said his medication has been stolen in shelters before. **(Factor 2)** *Progress assessment:* Member feels his medications are safe in group home lockers. CM helped the member set up a calendar pill case and clock alarm as medication reminders. CM arranged van transportation to twice weekly therapy sessions. CM assessed PHQ score at weekly call on 4/28/2018. Score was 16 (9 less than baseline). Member stated that housing greatly improved depression. Therapy sessions adjusted to weekly. CM assessed PHQ score at weekly call on 7/28/2018. Score was 12 (11 less than baseline). **(Factor 5)**	
Goal 2 completed:	7/28/2018. ***Note:*** *Member attends therapy. Member can navigate bus lines without anxiety; assisted transportation to sessions discontinued.* **(Factor 5)**
Follow-up and communication plan:	CM scheduled weekly follow-up calls at 5pm on Fridays via the group home's phone line. CM gave member direct emergency line and is working to secure cell phone for member. **(Factor 3)**
Self-management plan:	• Member will attend weekly follow-up calls on Fridays at 5pm via ***-***-****. • Member will continue to follow rules of group home. • Member will alert CM if changes to housing occur. • Member will use alarm clock reminders to take medication on schedule. Member and CM will discuss monthly refills to medications box. • CM arranges medication to be mailed to group home; member agrees to verify medication with CM during weekly calls. • Member attends therapy sessions and alerts group home staff to dramatic changes in mood (e.g., suicidal ideation). • Member will work with group home staff and other residents to learn bus routes and how to change buses on route. **(Factor 4)** ***Note*****:** *Member signed and has copies of the agreed-on self-management and case management plans. Signed copies attached.* **(Factor 4)**

Element F: Experience With Case Management—*Refer to Appendix 1 for points*

At least annually, the organization evaluates experience with its complex case management program by:

1. Obtaining feedback from members.

2. Analyzing member complaints.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys. For First Surveys: NCQA reviews the organization's most recent annual data collection and evaluation report.

For Renewal Surveys: During the most recent year, the organization obtains and analyzes member feedback about:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

During the previous year, the organization obtains and analyzes member feedback about:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months; at least once during the prior year for the percentage of members component of factor 1.

Explanation

***Factor 1:* Analyzing member feedback**

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the complex case management programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may assess the entire population or draw statistically valid samples.

If the organization uses a sample, it describes the sample universe and the sampling methodology.

If satisfaction surveys are conducted at the corporate or regional level, results are stratified at the accreditable entity level for analysis and to determine actions. CAHPS and other general survey questions do not meet the intent of this element.

The organization conducts a quantitative data analysis to identify patterns in member feedback, and conducts a causal analysis if it did not meet stated goals.

Factor 2: **Analyzing member complaints**

The organization analyzes complaints to identify opportunities to improve satisfaction with its complex case management program.

Exceptions

None.

Examples

Member feedback questions

1. Did the case manager help you understand the treatment plan?
2. Did the case manager help you get the care you needed?
3. Did the case manager pay attention to you and help you with problems?
4. Did the case manager treat you with courtesy and respect?
5. How satisfied are you with the case management program?

Table 1: Annual complex case management member satisfaction survey results (N = Number of respondents)

How Satisfied Are You…?	Very Satisfied		Satisfied		Combined		Sample Size	90% Goal Met?
	N	%	N	%	N	%		
With how the case manager helped you understand the doctor's treatment plan	75	60%	25	20%	100	80%	125	No
With how the case manager helped you get the care you needed	80	64%	35	28%	115	92%	125	Yes
With the case manager's attention and help with problems	70	56%	45	36%	1151	92%	125	Yes
With how the case manager treated you	85	68%	35	28%	120	96%	125	Yes

The Complex Case Management Team and the QI staff conducted a root cause analysis of the areas where goals were not met.

Table 2: Member feedback qualitative analysis

Root Cause/Barrier	Opportunity for Improvement	Prioritized for Action? (Y/N)
Members do not understand the treatment plan	Case managers identify health literacy issues and member preferences for information early in the case management process	Y

Complaints

- Limited access to case manager.
- Dissatisfaction with case manager.
- Timeliness of case management services.

Table 3: Complaint volume

Complex Case Management Complaints	Q1	Q2	Q3	Q4	Total 2019	Total 2018
Access to case manager	2	0	0	1	3	4
Dissatisfaction with case manager	1	2	0	1	4	5
Timeliness of case management services	1	0	2	2	5	5
Inquiries	3	1	2	4	10	12
Total case management	7	3	4	8	22	26

Findings

There were 22 complex case management complaints in 2019; there were 26 in 2018. Totals by category were also lower in 2019 than in 2018. Given the volume of cases over the past year, the numbers and types of complaints do not present opportunities for improvement.

The organization will continue to track and trend complaints and grievances annually, and compare results with the previous year's performance.

PHM 6: Population Health Management Impact
—Refer to Appendix 1 for points

The organization measures the effectiveness of its PHM strategy.

Intent

The organization has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement.

Summary of Changes

Clarifications

- Added "reports" as a data source and revised the look-back period for First and Renewal surveys to at least once during the prior year (Element A).
- Revised the Explanation for *factor 3 (interpretation of results)* (Element A).
- Revised the look-back period for First and Renewal Surveys to at least once during the prior year (Element B).
- Deleted the exception that reads, "This element is NA for 2018" (Element B).

Element A: Measuring Effectiveness—*Refer to Appendix 1 for points*

At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:

1. Quantitative results for relevant clinical, cost/utilization and experience measures.

2. Comparison of results with a benchmark or goal.

3. Interpretation of results.

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First and Renewal Surveys: NCQA reviews the organization's plan for its annual comprehensive analysis of PHM strategy impact. NCQA also reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and Renewal Surveys: At least once in the prior year.

Explanation

This element is a structural requirement. The organization must present its own materials.

The organization conducts an annual comprehensive, quantitative, analysis of the impact of the organization's PHM strategy.

***Factor 1:* Quantitative results**

Relevant measures align with the areas of focus, activities or programs as described in PHM 1, Element A. The organization describes why measures are relevant. Measures may focus on one segment of the population or on populations across the organization.

Clinical measures

Measures can be activities, events, occurrences or outcomes for which data can be collected for comparison with a threshold, benchmark or prior performance. Clinical measures may be:

1. *Outcome measures:* Incidence or prevalence rates for desirable or undesirable heath status outcomes (e.g., infant mortality), ***or***
2. *Process measures:* Measures of clinical performance based on objective clinical criteria defined from practice guidelines or other clinical specifications (e.g., immunization rates).

Cost/Utilization measures

Utilization is an unweighted count of services (e.g., inpatient discharges, inpatient days, office visits, prescriptions). Utilization measures capture the frequency of services provided by the organization. Cost-related measures can be used to demonstrate utilization. The organization measures cost, resource use or utilization.

Cost of care considers the mix and frequency of services, and is determined using actual unit price per service or unit prices found on a standardized fee schedule. Examples of cost of care measurement include:

- Dollars per episode, overall or by type of service.
- Dollars per member, per month (PMPM), overall or by type of service.
- Dollars per procedure.

Resource use considers the cost of services in addition to the count of services across the spectrum of care, such as the difference between a major surgery and a 15-minute office visit.

Experience

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may also analyze complaints to identify opportunities to improve satisfaction.

The organization analyzes feedback from at least two types of programs. The organization may use its complex case management member experience results and member experience results from one other program or service (e.g., disease management program or wellness program).

CAHPS and other general survey questions do not meet the intent of this element.

Factor 2: **Comparison of results**

The organization performs quantitative data analysis that compares results with an established, explicit and quantifiable goal or benchmark. Analysis includes past performance, if a previous measurement was performed.

Tests of statistical significance are not required, but may be useful when analyzing trends.

Factor 3: **Interpretation of results**

Measures are assessed together to provide a comprehensive analysis of the effectiveness of the PHM strategy. Interpretation is more than simply a presentation of results; it gives the organization insight into its PHM programs and strategy, and helps it understand the programs' effectiveness and impact on areas of focus. The organization conducts a qualitative analysis if stated goals are not met.

Note:

- *Participation rates do not qualify for this element.*
- *If the organization uses SF-8®, SF-12® or SF-36® to measure health status, results may count for two measures of effectiveness: one each for physical and mental health functioning.*

Exceptions

None.

Examples

Factor 1

Utilization includes measures of waste, overutilization, access, cost or underutilization.

Experience

- Patient Health Questionnaire (PHQ-9).
- Patient-Reported Outcomes Measurement Information System (PROMIS) tools.
- Program-specific surveys.

Element B: Improvement and Action—*Refer to Appendix 1 for points*

The organization uses results from the PHM impact analysis to annually:

1. Identify opportunities for improvement.

2. Act on one opportunity for improvement.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First and Renewal Surveys: NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

This element is a structural requirement. The organization must present its own materials.

Factor 1: **Opportunities for improvement**

The organization uses the results of its analysis to identify opportunities for improvement, which may be different each time data are measured and analyzed. NCQA does not prescribe a specific number of improvement opportunities.

Factor 2: **Act on opportunity for improvement**

The organization develops a plan to act on at least one identified opportunity for improvement.

Exceptions

None.

Examples

None.

PHM 7: Delegation of PHM—*Refer to Appendix 1 for points*

If the organization delegates NCQA-required PHM activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated PHM activities.

Summary of Changes

Clarifications

- Element B: Provision of Member Data to the Delegate is now factor 5 in Element A: Delegation Agreement (Elements A).
- Revised the look-back period for new requirements for Renewal Surveys to 12 months from 6 months (Elements A, B, D).
- Revised the look-back period to from 6 months to 12 months for Renewal Surveys (Element B).
- Revised the use of collaborative language in the Related information (Element B).
- Added a *Related information* section and the use of collaborative language (Element C).

Deletions

- Eliminated *Element C: Provisions for PHI* and relettered the remaining elements.

Element A: Delegation Agreement—*Refer to Appendix 1 for points*

The written delegation agreement:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegated entity's performance.**
5. **Describes the process for providing member experience and clinical performance data to its delegates when requested.**
6. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 6 factors	The organization meets 5 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in factor 5.

For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process. This documentation of notification is not required to be mutually agreed upon.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 12 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5, 11; Element D, factor 5; Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect during the look-back period.

The delegation agreement describes all delegated PHM activities. A generic policy statement about the content of delegated arrangements does not meet this element.

Factor 1: **Mutual agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

Factor 2: **Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the PHM activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
- The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other PHM functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

Factor 3: **Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about PHM delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited/Certified delegates.

***Factor 4:* Performance monitoring**

The delegation agreement specifies how the organization evaluates the delegate's performance.

***Factor 5:* Providing member and clinical data**

The organization provides:

- *Member experience data:* Complaints, CAHPS 5.0H survey results or other data collected on members' experience with the delegate's services.
- *Clinical performance data:* HEDIS measures, claims and other clinical data collected by the organization. The organization may provide data feeds for relevant claims data or clinical performance measure results.

***Factor 6:* Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples

None.

Element B: Predelegation Evaluation—*Refer to Appendix 1 for points*

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Scoring

100%	80%	50%	20%	0%
The organization evaluated delegate capacity before delegation began	No scoring option	The organization evaluated delegate capacity after delegation began	No scoring option	The organization did not evaluate delegate capacity

Data source

Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

This element applies if delegation was implemented in the look-back period.

NCQA reviews the organization's predelegation evaluation for up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim and First Surveys: 6 months.
For Renewal Surveys: 12 months.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional PHM activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaboratives. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of PHM Program—*Refer to Appendix 1 for points*

For arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's PHM program.**
2. **Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.**
3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**
4. **Semiannually evaluates regular reports, as specified in Element A.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Reports

Scope of review

Factor 1 applies to Interim Surveys, First Surveys and Renewal Surveys.

All factors in this element apply to First Surveys and Renewal Surveys.

NCQA reviews a sample from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For Interim Surveys: NCQA reviews the organization's review of the delegate's PHM program.

For First Surveys: NCQA reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews, audits, performance evaluations and four semiannual evaluations

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: Once during the prior year.

For Renewal Surveys: Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5, 11; Element D, factor 5; Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA scores factor 2 and 3 "yes" if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

***Factor 1:* Review of the PHM program**

Appropriate organization staff or committee reviews the delegate's PHM program. At a minimum, the organization reviews parts of the PHM program that apply to the delegated functions.

***Factor 2:* Annual file audit**

If the organization delegates complex case management, it audits the delegate's complex case management files against NCQA standards. The organization uses either of the following to audit the files:

- 5 percent or 50 of its files, whichever is less.
- The NCQA "8/30 methodology" available at http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupportingDocuments.aspx

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

***Factor 3:* Annual evaluation**

No additional explanation required.

***Factor 4:* Evaluation of reports**

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is NA if the organization does not delegate complex case management activities.

Factors 2–4 are NA for Interim Surveys.

Related information

Use of collaboratives. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples None.

Element D: Opportunities for Improvement—*Refer to Appendix 1 for points*

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Scoring

100%	80%	50%	20%	0%
At least once in each of the past 2 years that the delegation arrangement has been in effect, the organization has acted on identified problems, if any	No scoring option	The organization has taken inappropriate or weak action, or has taken action only in the past year	No scoring option	The organization has taken no action on identified problems

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews reports for opportunities for improvement if applicable from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For First Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 12 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5, 11; Element D, factor 5; Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports, or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
  - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.

Proposed Population Health Management (PHM) Strategy Overview

Special Board of Directors' Quality Assurance Committee Meeting
January 17, 2019

Betsy Ha, RN, MS, Lean Six Sigma Master Black Belt
Executive Director, Quality & Analytics

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Agenda

- 2018 National Committee for Quality Assurance (NCQA) Standards Change
- Population Health Management Conceptual Framework
- New Standards Overview
- Timeline and Accomplishments To Date
- Proposed PHM Strategy
- Discussion and Feedback

2018 NCQA Standard Changes

OLD

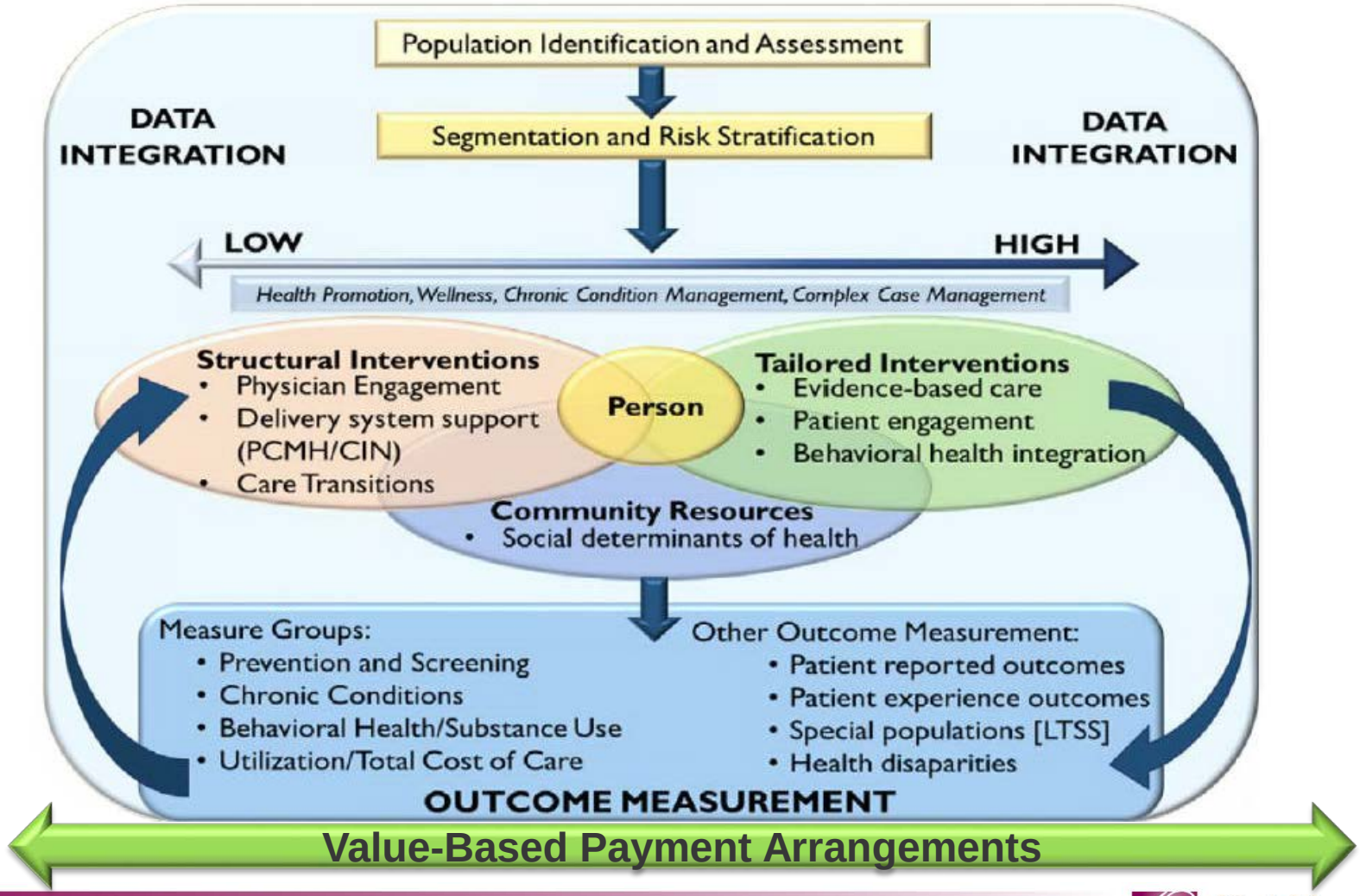
- Quality Improvement (QI) 5 Complex Case Management (CCM)
- QI 6 Disease Management (DM)
- Measuring Effectiveness by Individual Program

NEW

- Created Population Health Management (PHM) Standard Set
- Eliminated DM
- Move CCM under PHM
- Combined Measuring Effectiveness
- Added Standards
  - Data Integration
  - Delivery System Support

PHM Conceptual Framework

Figure 1.PHM Conceptual Model



Source: Diagram from ACAP presentation 3/29/17

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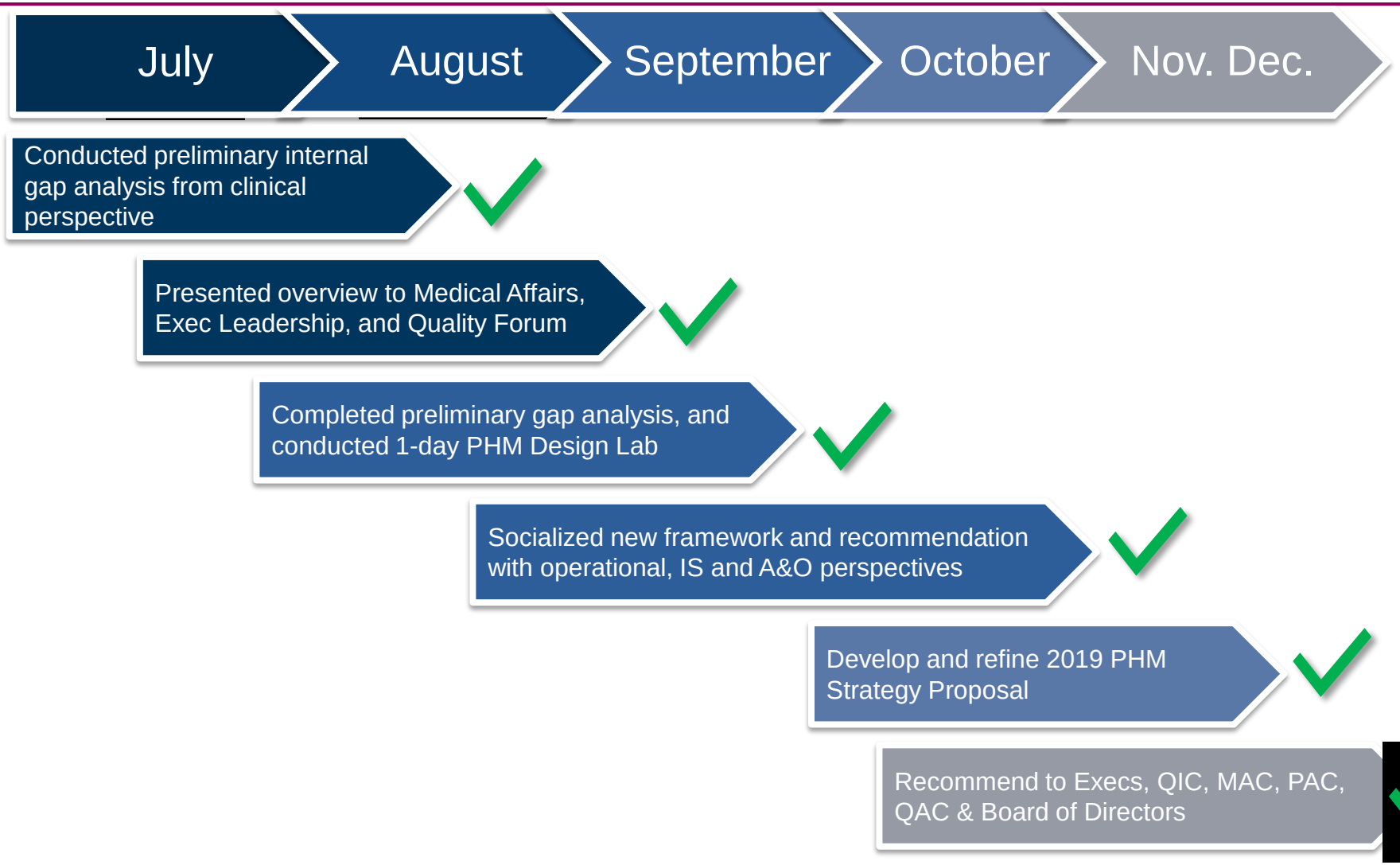
2018 Accomplishments



PHM1 Element A: Strategy
(Effective July 2018)

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

1. Goals and populations targeted for each of the four areas of focus
   - Keeping members healthy
   - Managing members with emerging risk
   - Patient safety or outcomes across settings
   - Managing multiple chronic illnesses
2. Programs or services offered to members
3. **Activities that are not direct member interventions**
4. How member programs are coordinated
5. How members are informed about available PHM programs

Data Source: Documented Process

PHM2 Element A: Data Integration
(Effective July 2018)

The organization assesses the needs of its population and determines actionable categories for appropriate interventions using:

1. Medical and behavioral claims or encounters
2. Pharmacy claims
3. Laboratory results
4. Health appraisal results
5. Electronic health records
6. Health services programs within the organization
7. Advanced data sources

Data source: Documented Process, Reports and Materials

PHM3 Element A: Practitioner or Provider Support (Effective July 2018)

The organization works with practitioners or providers to achieve population health management goals as part of Delivery System Support.

1. Sharing data
2. Offering evidence-based or certified decision-making aids
3. Providing practice transformation support to primary care practitioners
4. Providing comparative quality information on selected specialties
5. Comparative pricing information for selected services
6. One additional activity to support practitioners or providers in achieving PHM goals.

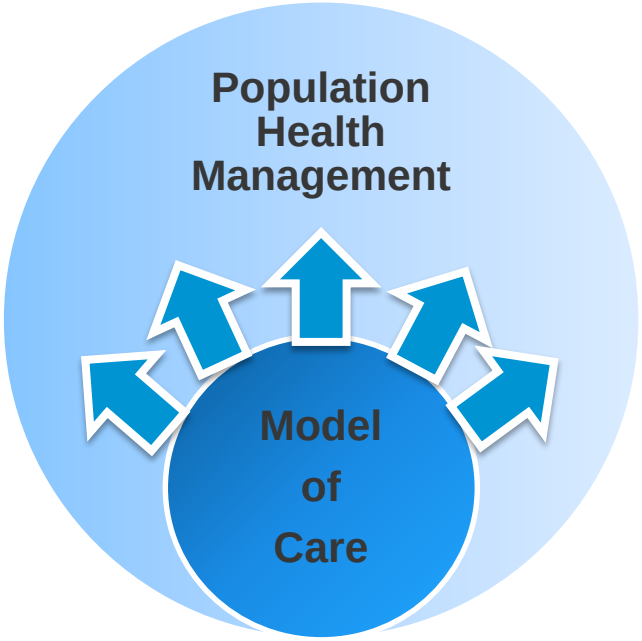
Data source: Documented Process and Materials

PHM1 Four Areas of Focus

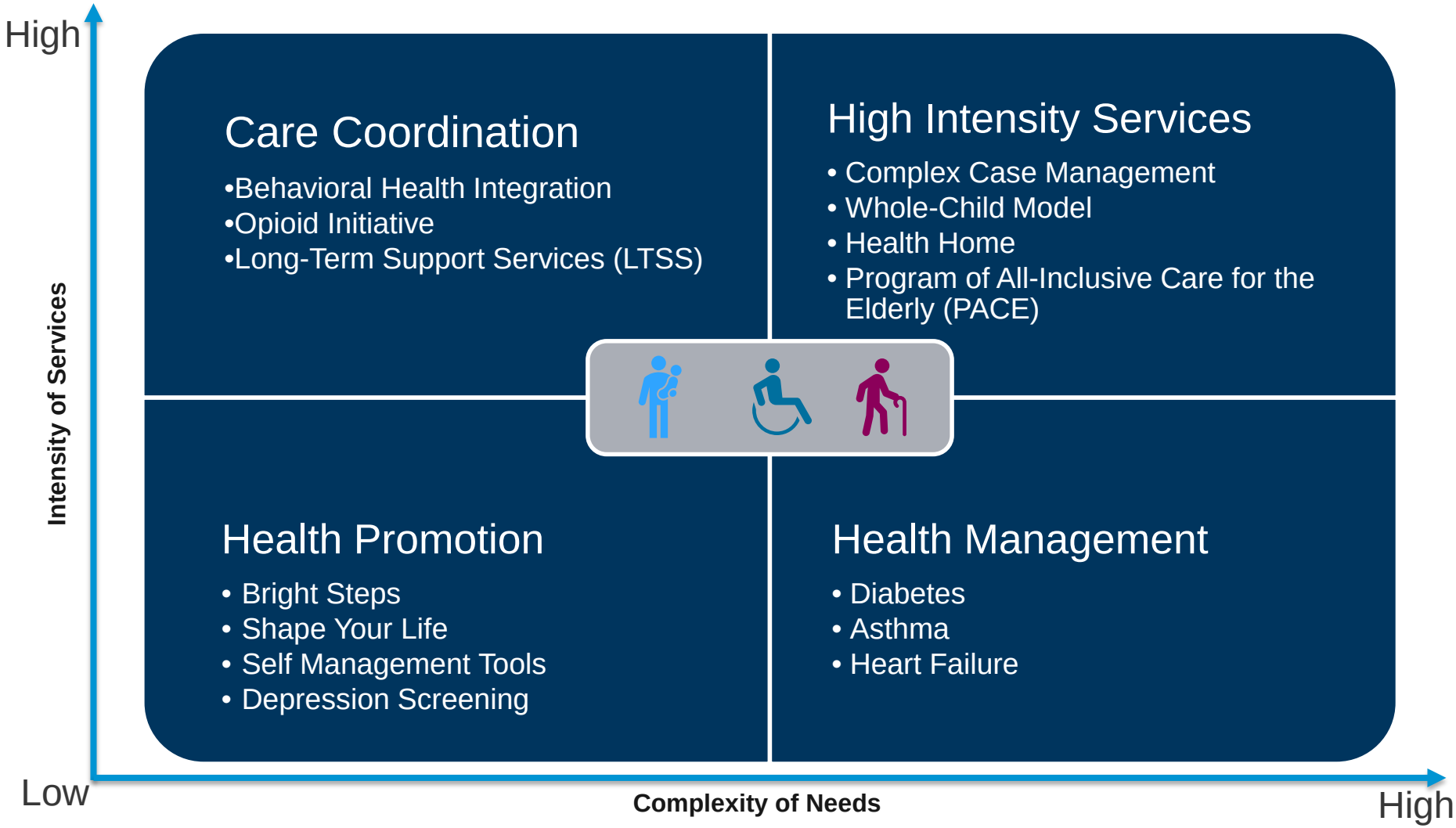
Improving Outcomes Across All Settings

PHM Strategy Intent and Approach

The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.



Current CalOptima Programs



Keeping Members Healthy

Bright Steps — Improve Prenatal and Postpartum Care

- Goals:
  - Improve 2018 Healthcare Effectiveness Data and Information Set (HEDIS) Prenatal Care rates (83.6%) from the 50th percentile to 75th percentile over a 24-month period.
  - Improve 2018 HEDIS Postpartum Care rates (69.44%) from 75th percentile to 90th percentile over a 24-month period
  - Reduce NICU Days/K
- Target Population:
  - Members in the first trimester of pregnancy
- Description of Programs or Services:
  - Support a healthy pregnancy and postpartum care aligned with the Comprehensive Perinatal Services Program (CPSP) guidelines
- Activities:
  - Member outreach and coordination with CPSP providers
  - Direct health education and support CPSP interventions

Keeping Members Healthy (Cont.)

Shape Your Life — Prevent Childhood Obesity

- Goal:
  - Maintain HEDIS Rates of 90th percentile or greater for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measures year-over-year for the following:
    - BMI Percentile (WCC)
    - Counseling for Nutrition (WCC)
    - Counseling for Physical Activity (WCC)
- Target Population:
  - Members age 5-18 with a Body Mass Index (BMI) equal to/or above the 85th percentile.
- Description of Programs or Services:
  - Health education and physical fitness activity program using evidence-based Kids-N Fitness curriculum conducted in 12 group classes in the community.
- Activities:
  - Active health education and member incentive for follow up visit with PCP after 6 consecutive classes

Managing Members with Emerging Risk

Health Management Programs — Improving Chronic Illness Care

- Goals:
  - Demonstrate significant improvement in 2018 HEDIS measures related to chronic illness management for Asthma Medication Ratio (AMR), Medication Management for People with Asthma (MMA), Monitoring for Patients on Persistent Medications (MPM), Controlling Blood Pressure (CBP) and Comprehensive Diabetes Care (CDC)
  - Increase member satisfaction with program to 90% in 2018
  - Reduce ED and IP rates by 3% for program participants in 2018
- Target population:
  - Members at risk for Asthma, Diabetes and/or Heart Failure

Managing Members with Emerging Risk (cont.)

Health Management Programs — Improving Chronic Illness Care (cont.)

- Description of Programs or Services:
  - Integrated health management and disease prevention programs to improve the health of our members with low acuity to moderate-risk chronic illness requiring ongoing intervention.
- Activities:
  - Member outreach
  - Health education classes
  - Self-management Tools
  - Telephonic coaching
  - Explore Board approval to expand member engagement leveraging virtual technology such as secured telehealth, texting, and remote patient monitoring (New Idea)

Managing Members with Emerging Risk (Cont.)

Opioid Misuse Reduction Initiative — Prevent and Decrease Opioid Addiction

- Goals:
  - Decrease the prevalence of opioid use disorder by implementing a comprehensive pharmacy program by December 2019
  - Decrease Emergency Department utilization related to substance disorder
- Target Population:
  - Members with diagnosis of opioid substance abuse disorder
- Description of Programs or Services:
  - A multi-department and health collaborative aimed at reducing opioid misuse and related death
- Activities:
  - Pharmacy lock-in program
  - Case management outreach
  - Physician academic detailing for safer prescribing
  - Develop access to Medication Assisted Treatment (MAT)

Patient Safety

Behavioral Health Treatment (BHT) Services

- Goal: Establish baseline in 2018
- Target Population:
  - Children with Autism Spectrum Disorder (ASD) who are eligible Medi-Cal members under 21 years of age Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate
- Description of Programs or Services:
  - Provide medically necessary BHT services to children with ASD. BHT is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior.
- Activities:
  - Treatment planning and implementation
  - Direct observation and measurement
  - Functional analysis

Patient Safety — New Idea

Practice Transformation — Improve Practice Health and Safety Leveraging the QI Practice Facilitators Team

- Goal:
  - Achieve and sustain 100% compliance of all Facility Site Review (FSR) audits year-over-year for primary care practices.
- Target Population:
  - Medi-Cal adults and children accessing primary care.
- Description of Programs or Services:
  - Enhancing the existing FSR nursing function by training nurses QI facilitation skills to address any gaps from FSR audit to improve compliance with practice health and safety standards at the practices sites of the CalOptima Community Network (CCN).

Patient Safety — New Idea

Practice Transformation — Improve Practice Health and Safety Leveraging the QI Practice Facilitators Team (cont.)

- Activities:
  - Develop Practice Facilitator function of the existing Facility Site Review (FSR) nurses to identify opportunities to improve practice site health and safety, provide QI technical assistance to these practices to achieve zero defect patient safety at the primary care practices.
  - Provide QI technical support to the safety net community clinics, Federally Qualified Health Center (FQHC), and PACE to promote patient safety practices.

Managing Members with Multiple Chronic Illnesses

Whole Child Model — Ensure Whole-Child Centric Quality and Continuity Care for Children with California Children's Condition (CCS) Eligible Conditions

- Goal:
  - Improve Children and Adolescent Immunization HEDIS measures to ≥ 75th percentile by December 2020 (excluding children and adolescent under cancer treatment)
- Targeted Population:
  - Children with CCS eligible conditions
- Description of Programs or Services:
  - The WCM program is designed to help children receiving CCS services and their families get better care coordination, access to care, and to promote improved health results.
- Activities:
  - Care Management
  - Personal Care Coordinator (PCC)

Managing Members with Multiple Chronic Illnesses (Cont.)

Health Home Program (HHP) Pilot — Improve Clinical Outcomes of Members With Multiple Chronic Conditions and Experiencing Homelessness

- Goal: Establish baseline in 2019
- Target Population:
  - Highest risk 3-5% of the Medi-Cal members with multiple chronic conditions meeting the following eligible criteria as determined by Department of Health Care Services (DHCS).
- Description of Programs or Services:
  - A pilot program of enhanced comprehensive care management program with wrap-around non-clinical social services for members with multiple chronic conditions and homelessness.
- Activities:
  - High touch core services as defined by DHCS

Delivery System Support (PHM3A)

Delivery System for Practitioner/Provider Support

- Information Sharing
  - Increase actionable data sharing to support academic detailing to improving outcomes across all settings.
- Practice Transformation Technical Assistance (New Idea)
  - Build upon internal FSR and QI capability to offer practice transformation support through Lean QI training, practice site facilitations, and/or individualize technical assistance to improve member experience.
- Provider Coaching (New Idea)
  - Offer individual provider coaching session and office staff workshops to improve quality of services and patient experience to targeted high volume CCN provider practices.

NCQA Timeline

Discussion and Feedback

Attachment 9 to May 7, 2020 Board of Directors Meeting– Agenda Item 8

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
mPulse Mobile	16530 Ventura Blvd., Suite 500	Encino	CA	91436

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8400

Recommended Action

Recommend approving the redirection of up to $2.0 million of IGT 9 funds originally allocated for the Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) Pilot towards contracting with a 24/7 virtual urgent care vendor for services that will include implementation and rapid deployment support for CalOptima Community Network (CCN) members during and after the COVID-19 pandemic

Background

On April 2, 2020, the Board of Directors (the Board) approved the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives within four focus areas: member access and engagement, quality performance, data exchange and support and other priority areas (refer to Attachment 1). Among these focus areas, the Board approved allocating $2.0 million for Expanded Office Hours to improve member access and engagement.

On May 7, 2020, CalOptima staff presented the Virtual Care Strategy and Roadmap (refer to Attachment 2) to provide additional access to quality care for our members and providers during and after the pandemic. One of the strategies introduced to the Board was to contract with a vendor offering virtual urgent care visits, including after-hour access for all CalOptima members regardless of network assignment for acute non-emergency medical conditions and behavioral health conditions. However, this strategy was postponed due to lack of available funding and deferred until CalOptima staff is able to identify appropriate funding.

As the COVID-19 pandemic continues to spread and disrupt the lives of many CalOptima members, CalOptima staff re-evaluated the structure of the Expanded Office Hours program and concluded that CalOptima is faced with new access challenges due to the COVID-19 pandemic that should be addressed. The Expanded Office Hours program was originally designed to provide additional office hours access to members in highly demanded and impacted areas. However, with the ongoing pandemic, members are less willing to come into the office for routine and preventive care services due to fear of COVID-19 and many provider offices are experiencing decreased office visits, and hence are less willing to expand their available office hours.

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Discussion

The Expanded Office Hours pilot was proposed as a two-year program to incentivize primary care providers and/or clinics to expand after-hour primary care services for CalOptima members in highly demanded and highly impacted areas. Unfortunately, this program was developed before the COVID-19 pandemic, and CalOptima staff now recommends shifting our efforts to support the urgent needs of our members through the use of virtual care.

CalOptima staff proposes redirecting the $2 million IGT-9 funds originally allocated for the Expanded Office Hours pilot to release a Request for Proposal (RFP) and selecting a vendor that meets our CCN members' medical needs and CalOptima's business requirements during the COVID-19 pandemic. Staff recommends starting this program with CCN members first and will consider extending it to other networks in the future. Staff will return to the Board to seek authority for approval to contract with the recommended vendor selected through the RFP process for services that will include a virtual care platform and virtual provider network, along with virtual care expertise to ensure a successful implementation of the 24/7 virtual urgent care initiative, including member and provider engagement and adoption.

With this proposed virtual care strategy, CalOptima staff believe that virtual urgent care after hours can improve member access to needed care on demand, decrease wait times, and reduce avoidable emergency department visits.

As discussed at prior CalOptima Board meetings, IGT 9 dollars are accounted for as part of the Medi-Cal capitation revenue CalOptima receives from the Department of Health Care Services (DHCS) in exchange for making covered, medically-necessary care available to assigned Medi-Cal beneficiaries. Any expenditures of IGT-9 funds not meeting these requirements are categorized by the DHCS as part of CalOptima's administrative expenses. The recommendation to redirect Board-allocated IGT 9 funds to virtual urgent care services is consistent with the purpose of the IGT 9 funds to cover medically necessary Medi-Cal services or qualifying quality initiatives.

Fiscal Impact

The recommended action to redirect $2.0 million in IGT 9 funds from the Expanded Office Hours Pilot to support 24/7 virtual urgent care services for CCN members during the pandemic has no net impact to CalOptima's fiscal position. IGT 9 revenue from DHCS in Fiscal Year 2019-20 was sufficient to cover the allocated expenditures and initiatives. This expenditure of IGT funds is for a restricted, one-time purpose for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

The recommended action is consistent with the original aim for IGT 9 to improve Member Access and Engagement and will enable CalOptima to provide increased access to quality care for CCN members during and after the pandemic.

Concurrence

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

Attachments

1. Board Action dated April 2, 2020, Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds
2. Board Action dated May 7, 2020, Consider Authorizing Virtual Care Strategy and Roadmap as Part of Coronavirus Disease (COVID-19) Mitigation Activities and Contract with Mobile Health Interactive Text Messaging Services Vendor

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Consider Ratifying Amendments to the Medi-Cal Shared-Risk Physician Group, Physician Hospital Consortium, and Health Maintenance Organization Health Network Contracts, Except Kaiser Foundation Health Plan, Inc.

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

Ratify amendments to the Health Network contracts for Medi-Cal Shared-Risk Physician Group (SRG), Physician Hospital Consortium (PHC), and Health Maintenance Organization (HMO) Health Networks, except Kaiser Foundation Health Plan, Inc., to:

1. Revise Whole Child Model (WCM) capitation rates;
2. Extend funding and revise reimbursement rates for Health Homes Program (HHP); and
3. Incorporate language changes including operational requirements.

Background/Discussion

CalOptima is currently contracted with twelve (12) separate Medi-Cal (MC) SRG, PHC, and HMO health network capitated and delegated entities. MC health network contracts renew on an annual basis, pending Board approval, each June. As needed, amendments are required to remain compliant with regulatory directives as well as CalOptima's internal policies and procedures and other changes.

Whole Child Model capitation rates:
CalOptima has received the DHCS updated reimbursement calculations for the WCM Program and based on the State funding, CalOptima is in a position to increase the capitation to the Health Networks.

Extension and funding for the Health Homes Program:
DHCS has extended HHP. Due to Coronavirus, this program has not realized the projected membership, and as such DHCS has increased funding for 2021. The Amendment will extend the program and rates to the Health Networks.

Operational requirements:
The Amendment will incorporate language changes including operational requirements such as: (i) increasing the notice requirement from 120 days to 180 days for termination for convenience, which allows a more appropriate timeframe for transition of members and related activities, including operational system changes; however, for one PHC health network CHOC Physicians Network and Children's Hospital of Orange County - the 120 day termination for convenience will continue until the end of fiscal year 2020-2021 to finish the remaining period for their current contracts; (ii) updating the Division of Financial Responsibility (DOFR); and (iii) contract language revisions, as appropriate, to align all Health Network contracts, such as the removal of the Member Liaison Program requirements which has been superseded by the Personal Care Coordinator (PCC) Program, requiring policies and procedures addressing offshore subcontracts related to Protected Health Information (PHI) and annual

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offshore attestation rather than CalOptima's prior approval of such subcontracts, clarifying regulatory requirements, and addressing legacy language.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020, incorporated MC Health Network capitation expenses of nearly $1.2 billion, including updated Hospital capitation rates and its associated impact to Shared Risk Pool funding.

The recommended action to ratify revised WCM base capitation rates results in an estimated increase of approximately 7.1% or $55.36 per member per month. The increase in capitation is due to changes in anticipated expenses for delegated services. The estimated annual impact is $7.2 million. Additional funding from DHCS is anticipated to be sufficient to cover the additional WCM expense.

The recommended action to ratify extended funding and revised reimbursement for the HHP core services capitation rate results in an estimated increase of approximately 22% or $130 per enrolled member per month. Extended funding and revised reimbursement for the HHP engagement services rate results in an estimated increase of approximately 3% or $0.52 per engaged member per month. These increases were primarily driven by the change in member distribution between Serious Mental Illness (SMI) and Chronic Condition (CC), as well as an additional Coronavirus adjustment to account for slower member ramp up and higher average acuity than anticipated. The estimated annual impact is $1.2 million. Additional funding from DHCS is anticipated to be sufficient to cover the additional HHP expense.

The recommended action to ratify the MC Health Network contracts to revise contract language is budget neutral. Contract language revisions as described above are operational in nature with no additional fiscal impact beyond what was incorporated in the CalOptima FY 2020-21 Operating Budget.

The proposed changes to clarify the DOFR are not anticipated to have a material impact to MC Health Network capitation or CalOptima financials.

Rationale for Recommendation

Ratifying the Amendments will ensure MC Health Networks and their providers aligned with current operational procedures.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	5785 Corporate Ave.	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

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Board of Directors Meeting
February 4, 2021

Joint Meeting of the Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee Board Report

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On December 10, 2020, the Provider Advisory Committee (PAC), Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC), and Whole-Child Model Family Advisory Committee (WCM FAC) held a special joint meeting to discuss topics of mutual interest.

Richard Sanchez, Chief Executive Officer, updated the committees on the delay of the Medi-Cal Rx transition until April 2021. He also introduced the new Executive Director, Public Affairs, Rachel Selleck to the committees.

Emily Fonda, M.D., Interim Chief Medical Officer, updated the committees on the current COVID-19 pandemic and the promising vaccines that are expected to soon be available to the Orange County community. Dr. Fonda also provided a brief update on the status of the E-Consults and telehealth programs.

Tom Megerian, M.D., Michael Weiss, M.D., and Charles Golden, M.D. with Children's Hospital of Orange County (CHOC) Thompson Autism Center presented on Trends in Early Diagnosis of Autism Spectrum Disorder. Dr. Chelsea O'Haire from the Center of Autism and Neurodevelopmental Disorders, University of California Irvine (UCI), School of Medicine presented on Trends in Adolescent Mental Health.

Junie Lazo-Pearson, Ph.D., BCBA, with Advanced Behavioral Health and the current PAC chair presented on Compassionate Care and Applied Behavior Analysis Treatment during the Pandemic. Betsy Ha, Executive Director, Quality and Population Health Management provided an update to Trauma Informed Care and Adverse Childhood Experiences Awareness.

The members of the MAC, OCC MAC, PAC, and WCM FAC appreciate the opportunity to update the Board on their current activities and plan to hold another joint meeting on March 11, 2021.

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