NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, DECEMBER 7, 2017
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Michelle Steel, Alternate

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

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

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

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

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. Behavioral Health Transition
   b. Program of All-Inclusive Care for the Elderly
   c. Children's Health Insurance Program
   d. Intergovernmental Transfers
   e. California Children's Services

PUBLIC COMMENTS

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

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the November 2, 2017 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the September 20, 2017 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee, the September 21, 2017 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the September 14, 2017 Joint Meeting of the CalOptima Board of Directors' Member and Provider Advisory Committees, the August 10, 2017 and October 12, 2017 Meetings of the CalOptima Board of Directors' Provider Advisory Committee, and the July 27, 2017 and October 26, 2017 Meetings of the CalOptima Board of Directors' OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee

3. Consider Approval of the Annual Investment Policy for Calendar Year 2018

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

5. Consider Approval of Updates to Policy for Acceptable Use of Company-Issued Mobile Phones

6. Consider Ratification and Amendment of Contract with Housecall Doctors Medical Group

7. Consider Revision to the Fiscal Year 2017-18 Board of Directors' Quality Assurance Committee Meeting Schedule

REPORTS

8. Consider Ratification of the Extension of the Contract with Liberty Dental Plan of California, Inc., for Dental Services Provided to OneCare and OneCare Connect Members for the 2018 Calendar Year

9. Consider Authorizing Contracting with or Amending Contracts with Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

10. Consider Authorizing and Directing Execution of Amendments to the Agreement with the California Department of Health Care Services for the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

11. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreement for the Medi-Cal Program with the California Department of Health Care Services

12. Consider Authorizing and Directing Execution of the Three-Way Agreement Between CalOptima, the California Department of Health Care Services and the Centers for Medicare & Medicaid Services for the Cal MediConnect Program

13. Consider Appointment to the CalOptima Board of Directors' Provider Advisory Committee

14. Consider Adoption of Resolution Approving Revised CalOptima 2018 Compliance Plan, and Authorizing the Chief Executive Officer to Approve Revised and Retired Office of Compliance Policies and Procedures

15. Consider Authorizing Extension of Disposable Incontinence Supplies Contracts with Caremax RM Corporation, Schraders' Medical Supply, Inc., and Byram Healthcare Centers; Consider Authorizing Request for Proposal (RFP) Process

16. Consider Authorizing Extension of Contract with American Logistics for Non-Medical Transportation Services

17. Consider Authorizing Extension of the Coordination and Provision of Behavioral Health Care Services Contract Between CalOptima and the County of Orange, Through its Division, the Orange County Health Care Agency, that Expires December 31, 2017

18. Consider Approval of Proposed New Behavioral Health Policies and Forms to Support the Administration of Behavioral Health Services for Medi-Cal Members Within CalOptima Internal Operations

19. Consider Authorizing Amendment of the Data Center Collocation Facility Contract with the County of Orange

20. Consider Authorization of Extension of Existing Contract with Edelstein Gilbert Robson & Smith for State Legislative Advocacy Services

21. Consider Authorizing the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program for Rate Year 2017-18 (IGT 8)

22. Consider Actions Related to CalOptima's Development Agreement with the City of Orange

23. Consider Approving Palliative Care Policy and Procedure (P&P) and Authorizing Execution of Agreement with the Department of Health Care Services to Fund the P&P's Implementation

ADVISORY COMMITTEE UPDATES

24. OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee Update

25. Member Advisory Committee Update

26. Provider Advisory Committee Update

INFORMATION ITEMS

27. October 2017 Financial Summary

28. Compliance Report

29. Federal and State Legislative Advocates Reports

30. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

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

MEMORANDUM

DATE:	December 7, 2017
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee

Behavioral Health (BH) Transition

In a short period of time, CalOptima has made good progress on our preparations for the transition of Medi-Cal BH services. As of this writing, CalOptima has contracted with 469 providers offering mental health (MH) and Applied Behavior Analysis (ABA) services, representing coverage for about 87 percent of the members receiving those services. This high percentage reflects our positive position when it comes to continuity of care and keeping members engaged with their current providers. Notices have been mailed to those remaining members who may need to select new providers, offering our support with making the change or requesting continuity of care arrangements. Under a continuity of care arrangement, a member may continue to see the same provider for up to a year if the provider agrees to accept the standard rate through a member-specific Letter of Agreement. To foster collaboration, CalOptima held four meetings in October and November with the ABA provider community, and a large orientation session is planned for December 20 to onboard all MH and ABA providers and share operational details, such as claims and authorization procedures. Finally, CalOptima has hired nearly all the necessary clinical and customer service staff needed to administer the BH benefits.

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

On October 27, the Department of Health Care Services (DHCS) released its final policy letter covering the PACE application process. The provisions in the final letter are largely consistent with the earlier draft, which was summarized in my November CEO Report. Importantly, the final letter supports your Board-directed PACE expansion approach, including allowing the use of Alternative Care Settings and community-based physicians. Seeking to expand PACE into South Orange County, CalOptima officially submitted its application for service area expansion on November 8. It can take six to nine months for review and approval by both DHCS and the Centers for Medicare & Medicaid Services (CMS).

Children's Health Insurance Program (CHIP)

CHIP provides health care coverage for children age 0–19 whose parents earn up to 266 percent of the Federal Poverty Level. This is an important population for CalOptima, representing approximately 112,000 of our Medi-Cal members. In California, CHIP receives approximately $3 billion in federal funding annually, yet all federal funding for CHIP nationwide expired on September 30, 2017. California is currently using reserve funding to pay for CHIP through

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yearend. In the meantime, activity to reauthorize funding is ongoing in Washington, D.C. On November 3, the House approved a bill (242–174) that extends funding for five years and creates a phased reduction in federal funding from the current rate of 88 percent federal/12 percent state to 65 percent federal/35 percent state across those years. The bill is now in the U.S. Senate. CalOptima recently sent letters of support to California's two U.S. Senators, urging their support to reauthorize CHIP funding. Currently, there is no timetable for final action on CHIP in the Senate, as Congress is focusing now on tax reform and legislation to fund the federal government beyond December 8.

Intergovernmental Transfers (IGTs)

CalOptima plays a significant role in obtaining additional funding for the local health care system. With our community funding partners and through several transactions, CalOptima has helped bring Orange County $337 million, including CalOptima's portion of almost $75 million. This month, your Board is scheduled to consider approving our participation in an eighth IGT (IGT 8). Recent changes will affect the amount of federal money received and the approved use of IGT funds. For IGT 8, we can expect a higher return because the funding formula will now consider our Medi-Cal Expansion and CHIP populations, which are funded using different federal/state payment ratios than Medi-Cal Classic. The July 2017 implementation of the Mega Reg changed the permissible use of IGT dollars to fund only CalOptima-covered Medi-Cal services, perhaps by increasing provider rates, rather than funding enhanced services beyond Medi-Cal, such as school-based vision care or community health center grants. This change does not impact our current IGT plans:

- IGT 5: The results of the Member Health Needs Assessment will drive IGT 5 spending in five Board-approved categories: Adult Mental Health, Children's Mental Health, Childhood Obesity, Strengthening the Safety Net and Improving Children's Health.
- IGT 6 and 7: Letters of Interest will guide grant funding allocations in three Board-approved areas: Opioid and Other Substance Overuse, Homeless Health, and Children's Mental Health.

California Children's Services (CCS)

As 2018 approaches, CalOptima is already beginning the yearlong process of transitioning the CCS program from a Medi-Cal carve-out administered by the Orange County Health Care Agency to the fully integrated Whole-Child Model (WCM), overseen by CalOptima. This effort a major undertaking, as Orange County has more than 13,000 CCS children, all of whom have significant medical conditions. CalOptima has created a plan for engaging stakeholders and obtaining Board approval for all the necessary changes. Active collaboration with the CCS community is also expected via your Board's newly approved WCM Family Advisory Committee. Later this month and in January, CalOptima will host meetings for providers and health networks affected by the transition. In late January, we plan a general stakeholder event that will include a guest speaker from DHCS. Overall, CalOptima is committed to a smooth transition focused on ensuring that CCS children have continued access to the same primary care physicians, specialists, hospitals, durable medical equipment suppliers, and other providers essential to their care.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

November 2, 2017

A Regular Meeting of the CalOptima Board of Directors was held on ~~September 7~~, November 2, 2017, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:00 p.m. Director Nguyen led the Pledge of Allegiance.

ROLL CALL

Members Present:	Paul Yost, M.D., Chair; Supervisor Lisa Bartlett, Ria Berger, Ron DiLuigi, Dr. Nikan Khatibi, Alexander Nguyen, M.D., Richard Sanchez (non-voting), Scott Schoeffel
Members Absent:	Lee Penrose, Vice Chair; Supervisor Andrew Do
Others Present:	Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Greg Hamblin, Chief Financial Officer; Ladan Khamseh, Chief Operating Officer; Len Rosignoli, Chief Information Officer; Suzanne Turf, Clerk of the Board

Chair Yost made the following announcement: Agenda Item 23, Consider Chief Executive Officer Performance Review, Compensation, and Amendment to Employment Contract, to be considered after closed session.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader announced that for the fourth year in a row, CalOptima was rated California's top Medi-Cal plan according to the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Ratings for 2017-18. Additionally, the Department of Health Care Services (DHCS) honored CalOptima with the Outstanding Performance Award for a Large Scale Medi-Cal Plan, which is based on 2016 Healthcare Effectiveness Data and Information Set (HEDIS®) results.

Mr. Schrader provided a brief update on the progress to expand the Program of All-Inclusive Care for the Elderly (PACE) into South Orange County, including the submittal of a Notice of Intent to Apply for Service Area Expansion to DHCS. It was noted that a Request for Proposal for Alternative Care Setting (ACS) sites was released, and it is anticipated that several Community-Based Adult Service centers will respond. In September, CalOptima staff submitted of a waiver to DHCS and the Centers for Medicare & Medicaid Services (CMS) regarding community-based physicians.

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Mr. Schrader introduced CalOptima's new Chief Financial Officer Greg Hamblin and Human Resources Executive Director Lori Shaw.

PUBLIC COMMENTS
There were no requests for public comment.

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the September 7, 2017 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the May 18, 2017 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the May 22, 2017 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee, and the July 13, 2017 Meeting of the CalOptima Board of Directors' Member Advisory Committee

3. Consider Approval of Proposed Pay for Value Payment Methodology for CalOptima Community Network Providers for Medi-Cal and OneCare Connect, and Distribution of Payment to Providers

4. Consider Approval of Revised Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 2017-18 for Member and Provider Incentives

5. Consider Approval of Proposed Fiscal Year 2019 (Measurement Year 2018) Pay for Value Programs for Medi-Cal and OneCare Connect

6. Consider Authorizing Additional Expenditures Related to the OneCare and OneCare Connect Sales Incentive Program

7. Consider Appointment of CalOptima Treasurer

8. **Acting as the CalOptima Foundation:** Consider Appointment of CalOptima Foundation Chief Financial Officer

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

REPORTS

9. Consider Accepting and Receiving and Filing Fiscal Year 2017 CalOptima Audited Financial Statements

Chief Financial Officer Greg Hamblin presented the recommended action to accept and receive and file the Fiscal Year (FY) 2017 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP. DeVon Wiens of Moss-Adams provided a brief overview of the FY 2017 audit results, and reported that an unmodified opinion will be issued indicating that

the FY 2017 financial statements fairly state the financial condition of CalOptima in all material respects.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors accepted and received and filed the FY 2017 CalOptima consolidated audited financial statements as submitted by Moss-Adams, LLP. (Motion carried 7-0-0; Vice Chair Penrose and Supervisor Do absent)***

10. **Acting as the CalOptima Foundation:** Consider Accepting and Receiving and Filing CalOptima Foundation Fiscal Year 2017 Audited Financial Statements

Action: ***On motion of Director Khatibi, seconded and carried, the CalOptima Foundation Board of Directors accepted and received and filed the FY 2017 CalOptima Foundation consolidated audited financial statements as submitted by Moss-Adams, LLP. (Motion carried 7-0-0; Vice Chair Penrose and Supervisor Do absent)***

11. Consider Adoption of Resolution Approving Updated Human Resources Policies

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors adopted Resolution No. 17-1101, approving CalOptima's updated Human Resources Policies GA.8031: Internship Program, and GA.8058: Salary Schedule as presented. (Motion carried 7-0-0; Vice Chair Penrose and Supervisor Do absent)***

12. Consider Medi-Cal Health Network Rate Adjustment for the Provision of the Screening, Brief Interventions, and Referral to Treatment Services

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors authorized the Chief Executive Officer to adjust rates for Medi-Cal health networks, excluding Kaiser, for the provision of the Screening, Brief Interventions, and Referral to Treatment (SBIRT) services effective January 1, 2018. (Motion carried 7-0-0; Vice Chair Penrose and Supervisor Do absent)***

13. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium (PHC) Health Network Physician Contracts for AMVI Care Health Network, Family Choice Network, and Orange County Advantage Medical Group to Modify the Professional Capitation Rate

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 DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into contract amendments of the CalOptima Medi-***

Cal Physician Hospital Consortium Health Network Physician Contracts, for AMVI Care Health Network, Family Choice Network, and Orange County Advantage Medical Group to revise the professional capitation rate associated with SBIRT services effective January 1, 2018, to the extent authorized by the Board in a separate action. (Motion carried 6-0-0; Vice Chair Penrose, Supervisor Do and Director Schoeffel absent)

14. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Physician Contract for CHOC Physicians Network to Modify the Professional Capitation Rate

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Chair Yost did not participate in the discussion and vote on this item due to his relationship as an anesthesiologist physician with CHOC, and passed the gavel to Director Berger.

Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into contract amendments of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Physician Contracts, for CHOC Physicians Network to revise the professional capitation rate associated with SBIRT services effective January 1, 2018, to the extent authorized by the Board in a separate action. (Motion carried 5-0-0; Chair Yost recused; Vice Chair Penrose, Supervisor Do and Director Schoeffel absent)***

15. Consider Authorizing Amendment of the CalOptima Medi-Cal Full-Risk Health Network Contracts for Heritage Provider Network, Inc., Monarch Family Healthcare and Prospect Medical Group to Modify the Professional Capitation Rate

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 DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into contract amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts for Heritage Provider Network, Inc., Monarch Family Healthcare, and Prospect Medical Group to revise the professional capitation rate associated with SBIRT services effective January 1, 2018, to the extent authorized by the Board in a separate action. (Motion carried 6-0-0; Vice Chair Penrose, Supervisor Do and Director Schoeffel absent)***

16. Consider Authorizing Amendment of the CalOptima Medi-Cal Shared Risk Group (SRG) Health Network Contracts for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Network to Modify the Professional Capitation Rate

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

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into contract amendments of the CalOptima Medi-Cal Shared Risk Group Health Network Contracts for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Network to revise the professional capitation rate associated with SBIRT services effective January 1, 2018, to the extent authorized by the Board in a separate action. (Motion carried 5-0-0; Supervisor Bartlett recused; Vice Chair Penrose, Supervisor Do and Director Schoeffel absent)***

17. Consider Recommended Appointments to the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors: 1) appointed the following agency-selected, non-voting liaison representatives to the OneCare Connect Member Advisory Committee: Jyothi Atluri, Orange County Social Services Agency Representative, and Amber Nowak, In-Home Supportive Services Public Authority Representative; and 2) appointed Kristin Trom as the OneCare Connect Member/Family Member Representative for a term ending June 30, 2019. (Motion carried 7-0-0; Vice Chair Penrose and Supervisor Do absent)***

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Sesha Mudunuri, Operations Executive Director, presented the recommended actions to: 1) Adopt Resolution 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).

After discussion of the matter, the Board revised the recommended eleven voting seats on the WCM-FAC to provide flexibility in membership, with a priority to family representatives, as follows: revise the number of family representatives from nine seats to a range of seven to nine seats; and revise the number of seats representing the interests of children receiving CCS services, including community-based organizations or consumer advocates, from two seats to a range of two to four seats. The Resolution Number was also corrected to read: Resolution No. 17-1102-01.

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Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors: 1) Adopted 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 Whole-Child Model program; membership of the eleven voting seats revised to a range of seven to nine family representative seats, and a range of two to four seats representing the interests of children receiving CCS services, with a priority to family representatives; and 2) Subject to approval of the California Department of Health Care Services, authorized a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee. (Motion carried 7-0-0; Vice Chair Penrose and Supervisor Do absent)***

19. 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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute an Amendment to the Primary Agreement between the California Department of Health Care Services and CalOptima related to the addition of an aid code related to the Medi-Cal Access Program for Pregnant Women. (Motion carried 7-0-0; Vice Chair Penrose and Supervisor Do absent)***

20. Consider Amendment of the AltaMed Health Services, AMVI/Prospect Medical Group, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Monarch HealthCare, Noble Community Medical Associates and United Care Medical Group OneCare Shared Risk Health Network Contracts to Extend These Agreements for the Period January 1, 2018 through December 31, 2018

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

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into amendments to extend the AltaMed Health Services, AMVI/Prospect Medical Group, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Monarch HealthCare, Noble Community Medical Associates and United Care Medical Group OneCare Shared Risk Health Network Contracts to extend these agreements for the period January 1, 2018 through December 31, 2018. (Motion carried 5-0-0; Supervisor Bartlett recused; Vice Chair Penrose, Supervisor Do and Director Schoeffel absent)***

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21. Consider Authorizing Amendment of the AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Orange County Advantage Medical Group, Prospect Health Plan and United Care Medical Group Cal MediConnect (OneCare Connect) Health Network Contracts

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

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into amendments to the AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Orange County Advantage Medical Group, Prospect Health Plan and United Care Medical Group OneCare Connect Health Network Contracts to extend these agreements through December 31, 2018, along with an additional one-year extension option, exercisable at CalOptima's discretion, and add any necessary language provisions based on changes to the three-way Cal MediConnect Contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid services (CMS) or other regulatory requirements. (Motion carried 5-0-0; Supervisor Bartlett recused; Vice Chair Penrose, Supervisor Do and Director Schoeffel absent)***

22. Consider Authorizing Expenditures in Support of CalOptima's Participation in the Family Voices of California's (FVCA) 2018 Annual Health Summit, in Preparation for the Upcoming Transition of the California Children's Services (CCS) Benefit to CalOptima

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors: 1) Authorized expenditures of up to $2,400 for CalOptima's participation in the Family Voices of California's 2018 Annual Health Summit on February 26-27 in Sacramento, which would cover the cost of three Orange County CCS families attending the Summit; 2) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3) Authorized the Chief Executive Officer to execute agreements as necessary for the events and expenditures. (Motion carried 7-0-0; Vice Chair Penrose and Supervisor Do absent)***

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ADVISORY COMMITTEE UPDATES

24. Provider Advisory Committee (PAC) Update

PAC Chair Teri Miranti provided an overview of the activities at the October 12, 2017 PAC meeting, including receiving an update on the behavioral health transition and the Drug Medi-Cal program referral process. Topics related to the November PAC meeting agenda were also shared with the Board.

25. OneCare Connect Cal MediConnect (Medicare and Medicaid Plan) Member Advisory Committee (OCC MAC) Update

Gio Corzo, OCC MAC Chair, reported that a quorum was not reached at the August and September 2017 OCC MAC meetings. A full report will be provided at the next Board of Directors meeting.

26. Member Advisory Committee (MAC) Update

MAC Chair Sally Molnar reported that a Special MAC meeting was held on September 14, 2017 to discuss and make recommendations regarding the proposed structure and composition of the Whole-Child Model Family Advisory Committee (WCM-FAC).

INFORMATION ITEMS

The following Information Items were accepted as presented:
27. September and August 2017 Financial Summaries
28. Compliance Report
30. CalOptima Community Outreach and Program Summary

29. Federal and State Legislative Advocates Report

Josh Teitelbaum and Geoffrey Verhoff of Akin Gump Strauss Hauer & Feld LLP provided an update on developments related to the Affordable Care Act, reauthorization of the Children's Health Insurance Program, Special Needs Plan reauthorization, and Community Health Center funding. It was noted that federal appropriations currently expire on December 8, 2017, and Congressional action will be required ahead of that date to avoid a federal government shutdown.

BOARD MEMBER COMMENTS

Board members extended their congratulations to CalOptima staff on receiving NCQA's top Medi-Cal plan in California, and for receiving the Outstanding Performance Award from DHCS.

Chair Yost announced that he had updated the scope of the current Legal Structure Ad Hoc, comprised of Supervisor Do, Director Schoeffel, and Chair Yost, to include a review of the Human Resources function.

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 3:30 p.m. pursuant to:
CS 1 Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer)

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

The Board reconvened to open session at 4:40 p.m. Chair Paul Yost reported that the Board met in closed session to review the performance of Michael Schrader, CalOptima's Chief Executive Officer (CEO), to hold a conference with labor negotiators, and to review the Board's position on CEO compensation. No reportable actions were taken in closed session.

23. Consider Chief Executive Officer Performance Review, Compensation, and Amendment to Employment Contract

Dr. Yost presented the recommended action to consider CEO performance review, compensation, and amendment to employment contract.

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors: 1) Based on Board member discussions and the analysis completed by our outside compensation consultant, the Board increased the CEO's base salary to $505,000, effective at the start of the next pay period; 2) Maintain the current arrangement of 4% annual merit increases based on the CEO receiving an evaluation score of at least "3-Meets Expectations," based on the 5 point review scale CalOptima uses to review all employees, for each review period for the CEO through the last one ending in June 2022. Consistent with the current arrangement with the CEO and the review cycle for all CalOptima employees, the CEO's review is to be conducted sometime on or after March 1 of each year, with any salary increase effective the following July 1, or as otherwise determined by the Board. For example, in the 2018 review cycle, the CEO's review will take place sometime after March 1, 2018, with any increase awarded taking effect on July 1, 2018. In the event that the Board determines, in its sole discretion, that the Employee has not met expectations, he shall be awarded no salary increase, or an increase in an amount less than 4% as determined by the Board; 3) In addition, for these same review periods, beginning with the 2018 review cycle, in the event that the CEO receives an evaluation score of "greater than or equal to 3-Meets Expectations," the Board to further revise the CEO's compensation to include incentive compensation tied to specific performance metrics before or early in each annual review cycle, and award the CEO incentive compensation up to a maximum of 10% of his annual salary for the year covered, with the percentage of this total potential incentive award tied directly to the percentage of the specific performance metrics achieved during the review period, as determined by the Board. Prior to July 1, 2023, the Board shall consider whether to continue this performance evaluation and compensation methodology; and 4) Authorize the Chairman of the Board of Directors to amend the CEO's**

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contract, with the assistance of legal counsel, to reflect these changes. (Motion carried 7-0-0; Vice Chair Penrose and Supervisor Do absent)

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 4:50 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Attachment: CEO Incentive Goals for FY 2017-18

Approved: December 7, 2017

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CEO Incentive Goals for FY 2017-18

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment	Comment/Notes
Innovation Pursue innovative programs and services to optimize member access to care	1. Behavioral Health	15	Integrate administration of behavioral health services into CalOptima operations for go-live on January 1, 2018	This shall include workshops for ABA providers, credentialing, provider network, supervision levels, authorizations, claims, and call center
	2. New State programs	10	As applicable depending on the program, complete go-live or keep on-schedule with upfront state/federal readiness requirements that are due on or before June 30, 2018	Programs and timelines: • Palliative Care (Jan 2018) • Whole Child Model (Jan 2019)
	3. Expanded PACE Access	10	Initiate, complete steps, and stay on-schedule for state/federal approval/waiver process for 1) Service Area Expansion into South County using ACS model of satellite sites, and 2) Community Based Physicians	This does not include implementation, since the approval/waiver process could span beyond the end of the fiscal year given that both State and CMS approvals are required.
Value Maximize the value of care for members by ensuring quality in a cost-effective way	4. NCQA Rating	20	Obtain NCQA rating of top Medi-Cal managed care plan in California for fourth consecutive year	Each year, NCQA publishes the results in late September. This comprehensive rating covers member satisfaction and quality of care.
Partnerships and Engagement Engage providers and community partners in improving the health status and experience o members	5. MLR audits of health networks	10	Complete the following: • Establish audit methodology and guidelines • Hold educational sessions for health networks • Audit all health networks • Issue CAPs as needed and follow up	

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Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment	Comment/Notes
Workforce Performance Attract and retain an accountable and high-performing workforce capable of strengthening systems and processes	6. CalOptima Strategic Plan	10	Prepare a progress report on CalOptima's Strategic Plan and related initiatives and report the results to the community twice a year.	
	7. CalOptima Board Packets	10	Publish CalOptima Board packets in final form on Thursdays one week before the meetings.	The purpose is to give the Board and public adequate time to review the materials in advance of the Board meetings, while also including timely information.
Financial Strength Provide effective financial management and planning to ensure long-term financial strength	8. Administrative Ratios	15	Complete fiscal year 17/18 with an efficient administrative ratio of 5.0% or less	Significant pressures on ALR include behavioral health, non-emergency medical transportation, and the Mega-Reg.

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

September 20, 2017

CALL TO ORDER
Chair Paul Yost called the meeting to order at 3:03 p.m. Director Nguyen led the pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Ria Berger; Alexander Nguyen M.D.

Members Absent: Dr. Nikan Khatibi

Others Present: Michael Schrader, Chief Executive Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Caryn Ireland, Executive Director Quality Analytics; Gary Crockett, Chief Counsel; Suzanne Turf, Clerk of the Board

PUBLIC COMMENTS
There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the May 22, 2017 Special Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Director Berger, seconded and carried, the Committee approved the Minutes of the May 22, 2017 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Dr. Khatibi absent)***

REPORTS

2. Consider Recommending Board of Directors' Approval of the Proposed Pay for Value (P4V) Payment Methodology for CalOptima Community Network (CCN) Providers for Medi-Cal and OneCare Connect, and Distribution of Payments to Providers

Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to recommend Board of Directors' approval of the Measurement Years 2016 and 2017 payment methodology for the P4V Program for CCN providers for Medi-Cal and OneCare Connect (OCC), subject to regulatory

approval, as applicable; and authorize distribution of P4V payments based on this methodology in an amount not to exceed $2 per member per month (PMPM) for CCN Medi-Cal and $20 PMPM for CCN OneCare Connect membership.

A review of the recommended scoring methodology for CCN providers was provided to the Committee. Performance allocations are distributed based upon final calculation and validation of each measurement rate. To quality for payment for each of the clinical measures, the provider must meet the noted minimum denominator and distribution. Medi-Cal CCN provider payments for clinical measures will be based on the provider's measurement rate for each clinical performance measure and member months. As CalOptima did not obtain individual provider satisfaction data, it was recommended that CAHPS payments be distributed based on the provider's percent of total CCN Medi-Cal membership. OneCare Connect (OCC) CCN provider payments will be based on the provider's percent of total CCN OCC membership. In order to qualify for payments, a physician or clinic must be contracted with CalOptima during the entire measurement period and the period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

After discussion of the matter, the Committee took the following action.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of Measurement Years 2016 and 2017 payment methodology for the P4V Program for CalOptima CCN providers for Medi-Cal and OCC, subject to regulatory approval, as applicable (Attachment 1); and authorize distribution of P4V payments based on this methodology in an amount not to exceed $2 pmpm for CCN Medi-Cal and $20 pmpm for CCN OCC membership. (Motion carried 3-0-0; Dr. Khatibi absent)***

3. Consider Recommending Board of Directors Approval of Revised Medi-Cal Quality Improvement and Accreditation Activities during CalOptima Fiscal Year (FY) 2017-18 for Member and Provider Incentives

Dr. Bock presented the action to recommend Board of Directors' approval of proposed revisions to Member and Provider incentive program start and end dates, subject to regulatory approval, as applicable. The following program extensions were requested: Cervical Cancer Provider - Provider Extended Hours and Provider Office Staff initiatives extended to December 31, 2017; member incentives related to Breast Cancer Screening extended to December 31, 2017; and Postpartum Care member incentive program extended to November 5, 2017.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of proposed revisions to Member and Provider incentive program start and end dates, subject to regulatory approval, as applicable. (Motion carried 3-0-0; Dr. Khatibi absent)***

4. Consider Recommending Board of Directors Approval of 2018 Pay for Value (P4V) Measure Changes

Caryn Ireland, Executive Director Quality Analytics, presented the action to recommend Board of Directors' approval of proposed Fiscal Year 2019 (Measurement Year 2018) Pay for Value Programs

for Medi-Cal and OneCare Connect, which defines measures and allocations for performance and improvement, as described in Attachment 1, subject to regulatory approval, as applicable.

The recommended changes to MY 2018 Medi-Cal P4V program are as follows: replace Medication Management for People with Asthma (MMA) - Total 75% compliance, with MMA 5-11 years (child), and MMA 19-50 years (adult); retire Comprehensive Diabetes Care - HbA1c testing, and CAHPS Getting Appointment with a Specialist, Timely Care and Service Composite, and Rating of all Healthcare; add three new clinical measures - Well Child visits in the first 15 months of Life (W15) - six well child visits, Comprehensive Diabetes Care (CDC) - HbA1c <8 (adequate control), and Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB); and add three new Member Experience measures (CAHPS Surveys - Medi-Cal Adult and Child) - Getting Needed Care, Getting Care Quickly, and How well Doctors Communicate.

Recommended changes to the Measurement Year 2018 OneCare Connect P4V Measure include: retire Antidepressant Medication Management (AMM) – Continuation and Acute Phase Treatment, and Controlling Blood Pressure (CBP; and add two new measures – Breast Cancer Screening, and Comprehensive Diabetes Care (CDC) – HbA1c. Ms. Ireland corrected the CDC HbA1c measure to read ">9 (poor control)".

After discussion of the matter, the Committee took the following action.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of the proposed Fiscal Year 2019 (Measurement Year 2018) Pay for Value Programs for Medi-Cal and OneCare Connect, which defines measures and allocations for performance and improvement, as described in Attachment 1, subject to regulatory approval, as applicable, with the noted correction. (Motion carried 3-0-0; Dr. Khatibi absent)***

5. Receive and File the Updated 2016 Utilization Management Program Evaluation

Tracy Hitzeman RN CCM, Executive Director, Clinical Operations, presented the recommended action to receive and file the updated 2016 Utilization Management (UM) Program Evaluation. Ms. Hitzeman noted that CalOptima's NCQA re-accreditation preparation leverages consultant reviews of the 2016 UM Program Plan, Work Plan, and Program Evaluation. A review of the Program Evaluation indicated that additional narrative detail was needed to improve the readability and ease of understanding. Revisions included enhancement of Utilization Outlier Trend tables, additional detail added to acute and long-term support services facility utilization evaluation, and expanded narrative regarding member and provider satisfaction.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee received and filed the updated 2016 Utilization Management Program Evaluation as presented. (Motion carried 3-0-0; Dr. Khatibi absent)***

6. Receive and File the 2016 Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment Performance Improvement Plan Evaluation

Miles Masatsugu, M.D., Medical Director, PACE, presented the action to receive and file the 2016 PACE Quality Assessment Performance Improvement (QAPI) Plan Evaluation. It was reported that

PACE reached its goal on 10 of the QAPI elements, a successful Year 3 CMS/DHCS audit was completed, membership grew to 182 participants, and all utilization goals were met. Opportunities for improvement in 2017 include patient satisfaction, membership, utilization management, and increasing the quality of care elements.

Action: ***On motion of Director Berger, seconded and carried, the Committee received and filed the 2016 Program of PACE Quality Assessment Performance Improvement Plan Evaluation as presented. (Motion carried 3-0-0; Dr. Khatibi absent)***

INFORMATION ITEMS

7. PACE Member Advisory Committee Update
This Information Item was accepted as presented.

8. 2017 HEDIS Results
Ms. Ireland provided a brief update on the 2017 HEDIS results. It was noted that the HEDIS results compared to CalOptima goals were all met. HEDIS regulatory reporting included patient level detail files for Medicare and Medicaid submitted to the Centers for Medicare & Medicaid Services (CMS) and NCQA respectively, and 49 measures required medical record review. A medical record retrieval rate of 98% was noted. A review of the HEDIS results was provided to the Committee.

9. Behavioral Health Update
Donald Sharps, M.D., Medical Director, Behavioral Health Integration, provided an overview of the Customer Service Call Center Metrics and CalOptima's audit of the call center. The monthly average of incoming calls was 4,567 during the second quarter. Dr. Sharps also provided an update on utilization trends, and the Drug Medi-Cal Memorandum of Understanding between CalOptima and the Orange County Health Care Agency.

10. Program Updates: Shape-Your-Life and CalOptima Perinatal Health Program
Pshyra Jones, Health Education and Disease Management Director, provided a brief overview of the Shape-Your-Life (SYL) program, a childhood obesity program. In July 2017, Request for Proposals were issued and the responses are currently under review. It is anticipated that a contract will be awarded in October 2017. Newsletters have been redesigned, and CalOptima has sponsored several community classes that are 4 to 6 weeks in length and offered in English and Spanish.

With regard to the Comprehensive Perinatal Services Program (CPSP), a Request for Information was released in August 2017 for CPSP-like services, and a CPSP provider survey is in progress. Additionally, the County of Orange has several no-cost prenatal/postnatal resources for at-risk women.

11. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Report
This Information Item was accepted as presented.

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b. Member Trend Report

Ana Aranda, Interim Director, Grievance and Appeals, provided an update on OneCare Connect transportation and improvements made during the second quarter.

COMMITTEE MEMBER COMMENTS

Dr. Bock announced that CalOptima was rated California's top Medi-Cal plan, according to the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Ratings 2017-2018. It is the fourth year in a row that NCQA has named CalOptima best overall in the state.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 4:55 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: November 15, 2017

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

SEPTEMBER 21, 2017

CALL TO ORDER
Chair Lee Penrose called the meeting to order at 2:14 p.m. Director Schoeffel led the Pledge of Allegiance.

Members Present: Lee Penrose, Chair; Scott Schoeffel

Members Absent: Ron DiLuigi

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

MANAGEMENT REPORTS

Chief Financial Officer (CFO) Report
Nancy Huang, Interim Chief Financial Officer, provided a brief update on the Department of Health Care Services' (DHCS) Medical Loss Ratio (MLR) audit for Medi-Cal Expansion members, which will be conducted after final approval of the audit methodology by the Centers for Medicare & Medicaid Services (CMS). It was also reported that Medi-Cal non-medical transportation services will be covered by Medi-Cal managed care plans effective October 1, 2017.

PUBLIC COMMENT
There were no requests for public comment.

INVESTMENT ADVISORY COMMITTEE UPDATE

1. Treasurer's Report

Ms. Huang presented an overview of the Treasurer's Report for the period April 1, 2017 through June 30, 2017. Based on a review by the Board of Directors' Investment Advisory Committee, all investments were compliant with Government Code section 53600 *et seq.*, and with CalOptima's Annual Investment Policy.

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CONSENT CALENDAR

2. Approve the Minutes of the May 18, 2017 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the April 24, 2017 Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

REPORTS

3. Consider Recommending that the Board of Directors Accept and Receive and File the Fiscal Year 2017 CalOptima Audited Financial Statements

Interim Chief Financial Officer Nancy Huang presented the action to recommend that the CalOptima Board of Directors accept and receive and file the Fiscal Year (FY) 2017 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP.

DeVon Wiens of Moss-Adams, LLP, CalOptima's independent financial auditor, presented the draft audit of the consolidated financial statement for the fiscal year ending June 30, 2017. A detailed review of the areas of audit emphasis were presented to the Committee for discussion, including capitation revenue and receivables, cash and investments, medical claims liability, and required communications. It was reported that Moss-Adams will issue an unmodified opinion on the financial statements indicating that the FY 2017 financial statements fairly state the financial condition of CalOptima in all material respects.

After discussion of the matter, the Committee took the following action.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee approved the draft Fiscal Year 2017 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP, and recommended that the Board of Directors accept and receive and file the final version. (Motion carried 2-0-0; Director DiLuigi absent)***

4. Consider Recommending Board of Directors' Authorization of Additional Expenditures Related to the OneCare and OneCare Connect Sales Incentive Program

Ladan Khamseh, Chief Operating Officer, presented the action to recommend the Board of Directors authorize expenditures of up to $334,960 from existing reserves for one-time expenses related to the OneCare and OneCare Connect sales incentive program in FY 2018.

At the September 7, 2017 meeting, the Board approved revisions to CalOptima Policy GA.8042: Supplemental Compensation, to include changes to the OneCare and OneCare Connect sales incentive program with additional direction to staff to return with a follow-up action to include the fiscal impact of the sales incentive program. It was noted that funding for OneCare and OneCare Connect sales incentive program in the last fiscal year was covered by the savings achieved from

CalOptima's vacancy factor. During the FY 2018 budgeting process, most of the open positions were removed from the Operating Budget to reduce CalOptima's overall budgeted administrative costs, which eliminated the possibility of funding the sales incentive program with savings from CalOptima's vacancy factor. As proposed, an allocation of up to $334,960 from existing reserves will be used to fund this recommended action through June 30, 2018.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended Board of Directors authorize expenditures of up to $334,960 from existing reserves for one-time expenses related to the OneCare and OneCare Connect sales incentive program in FY 2018. (Motion carried 2-0-0; Director DiLuigi absent)***

INFORMATION ITEMS

5. July 2017 Financial Summary

Ms. Huang presented an overview of the financial statements for the period ended July 30, 2017. It was noted that enrollment during the first month of FY 2017-18 for all lines of business was 787,686 members, an overall membership variance of -1.7%, primarily attributed to lower enrollment in Medi-Cal TANF child and TANF adult populations. Overall, CalOptima's non-operating income for the month of July was $2.7 million; medical loss ratio was 97.6%; and administrative loss ratio was reported at 3.2%.

The following Information Items were accepted as presented:

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

COMMITTEE MEMBER COMMENTS

Committee members thanked staff for their work on the FY 2017 audit.

ADJOURNMENT

Hearing no further business, Chair Penrose adjourned the meeting at 2:54 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: November 16, 2017

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MINUTES

JOINT MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' MEMBER ADVISORY COMMITTEE AND PROVIDER ADVISORY COMMITTEE

September 14, 2017

A Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) was held on Thursday, September 14, 2017, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Mirani, PAC Chair, called the meeting to order at 8:15 a.m., and MAC Chair Sally Molnar led the Pledge of Allegiance.

ESTABLISH QUORUM

Member Advisory Committee

Members Present: Sally Molnar, Chair; Patty Mouton, Vice Chair; Suzanne Butler, Connie Gonzalez, Donna Grubaugh, Jaime Muñoz, Velma Shivers, Christine Tolbert, Lisa Workman

Members Absent: Sandy Finestone, Carlos Robles, Ilia Rolon, Christina Sepulveda, Sr. Mary Therese Sweeney, Mallory Vega

Provider Advisory Committee

Members Present: Teri Miranti, Chair; Suzanne Richards, MBA, FACHE, Vice Chair; Anjan Batra, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Jena Jensen; Pamela Kahn, R.N.; John Nishimoto, O.D.; Mary Pham, Pharm.D, CHC; Pamela Pimentel, R.N.; Jacob Sweidan, M.D.

Members Absent: Alan Edwards, M.D.; Steve Flood; Craig Myers; George Orras, PhD;

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Becki Melli, Program Specialist; and Cheryl Simmons, Project Manager

PUBLIC COMMENTS

No requests for public comment were received.

Chief Executive Officer Report

Michael Schrader, Chief Executive Officer, provided an update on CalOptima's behavioral health transition plan that integrates administration of Medi-Cal covered Behavioral Health, which includes Mental Health and Applied Behavior Analysis services, within CalOptima internal operations effective January 1, 2018.

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Community Forum for Member and Provider Stakeholders

Homeless Initiatives

Susan Price, Director of Care Coordination, County of Orange, presented on the County's Homeless Initiatives and presented the following data on behalf of the County on homelessness. As of the January 2017 Housing and Urban Development (HUD) census of the homeless in Orange County, there were 2,584 unsheltered homeless and 2,208 sheltered homeless. Of those, 422 individuals were residing on the Santa Ana River Trail as of the survey date. The Courtyard at the Santa Ana Civic Center serves over 700 homeless during the day, and 400 homeless at night as a safe sleep shelter. The Bridges at Kraemer in north Anaheim has space for 100 per night with on-going construction to house an additional 100 beds, which is anticipated to be operational in late 2018. She also mentioned that Crisis Stabilization Units are being established with $23.9 million in funding from the County of Orange to increase the number of beds available for people in psychiatric crisis, which would allow homeless individuals to receive immediate psychiatric care through these units rather than sending homeless members in crisis as to the nearest emergency room.

Drug Medi-Cal and Substance Use Disorder

Sandra Fair, Administrative Manager, Behavioral Health Services, Orange County Health Care Agency, presented on Behavioral Health Services Drug Medi-Cal: An Organized Delivery System for Substance Use Disorder Services (SUD). Ms. Fair reviewed the 5-Year Pilot Project that was implemented after California received a waiver from the federal government to develop a pilot project to better serve individuals experiencing a substance use disorder, and who were eligible for Drug Medi-Cal (DMC) under the Affordable Care Act. She noted that approximately 900,000 Orange County residents are eligible Medi-Cal beneficiaries in Orange County, and estimated that between 7,000 and 13,000 Orange County residents may seek treatment for SUD services in a year. Ms. Fair added that the new model supports integrated services with mental health and physical health, including services provided by CalOptima.

Orange County Strategic Plan for Aging

Patty Mouton, Vice President of Outreach and Advocacy, Alzheimer's of Orange County and member of the MAC, presented the Orange County Strategic Plan for Aging. Ms. Mouton noted that by 2040, it is anticipated that nearly 1 in 4 individuals will be age 65 plus in Orange County. The strategic plan was developed to prepare Orange County for the growing numbers of older residents and the issues they will face. Ms. Mouton reviewed the plan and noted that it was developed through on-going collaboration, and finalized with a series of 18-month goals starting on July 1, 2017 and ending on December 31, 2018. During this 18-month timeframe, 10 initiatives will be developed, including: Healthcare, Elder Abuse Prevention and Awareness, Transportation, Housing, Technology, OC Successful Aging, Social Engagement, Food Security Fundraising and Sustainability and Communications.

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ADJOURNMENT
There being no further business before the Committees, the meeting adjourned at 10:16 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: October 12, 2017

/s/ Becki Melli
Becki Melli
Staff to the MAC

Approved: November 9, 2017

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MINUTES

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

August 10, 2017

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, August 10, 2017, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Miranti, PAC Chair, called the meeting to order at 8:04 a.m., and Member Flood led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Teri Miranti, Chair; Suzanne Richards, MBA, FACHE, Vice Chair; Anjan Batra, M.D.; Donald Bruhns; Alan Edwards, M.D.; Steve Flood; Jena Jensen; Pamela Kahn, R.N.; Craig G. Myers; John Nishimoto, O.D.; George Orras, Ph.D., FAAP; Pamela Pimentel, R.N.; Jacob Sweidan, M.D.
Members Absent:	Theodore Caliendo, M.D.; Mary Pham, Pharm.D, CHC
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Richard Helmer, M.D., Chief Medical Officer; Gary Crockett, Chief Counsel; Nancy Huang, Interim Chief Financial Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Candice Gomez, Executive Director, Program Implementation; Arif Shaikh, Director, Government Affairs; Cheryl Meronk, Director, Strategic Development; Kelly Rex-Kimmet, Director, Quality Analytics; Cheryl Simmons, Staff to the Provider Advisory Committee

MINUTES

Approve the Minutes of the June 8, 2017 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the June 8, 2017 meeting. (Motion carried 13-0-0; Members Caliendo and Pham absent)***

PUBLIC COMMENTS

No requests for public comment were received.

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Chair Miranti welcomed Craig G. Myers to the PAC as the new Community Health Centers Representative. Mr. Myers formerly held the Hospital seat from 2011-2013. The PAC also recognized Member Barry Ross for his six years of service as the Community Health Centers Representative. Mr. Ross thanked the PAC members, CalOptima leadership and staff for their support during the last six years.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, updated the PAC on healthcare reform as well as the Magellan contract for behavioral health services for Medi-Cal members. At the August 3, 2017 meeting, the CalOptima Board of Directors authorized extending the current contract with Magellan through December 31, 2017, and Board Chair Paul Yost formed an ad hoc to evaluate options for Board consideration, including a possible extension of the current contract with Magellan beyond December 31, 2017. Several PAC members indicated their support should CalOptima consider administering the Medi-Cal behavioral health benefit in-house, if necessary, on January 1, 2018.

Mr. Schrader also discussed the three-way non-binding Master Services Agreement that was approved by the Board at their August 3, 2017 meeting. The non-binding agreement between LA Care, Inland Empire Health Plan and CalOptima allows for partnership and engagement with the University of California (UC) Health System. The purpose of the agreement is to work with the UC system to contract with several of the UC HealthCare system hospitals such as UC Davis, UC Irvine and UCLA, including for services not available in Orange County. Currently CalOptima works with out of county providers including the University of Southern California (USC) Keck School of Medicine, City of Hope and Cedars Sinai to access such services as necessary.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, discussed the current OneCare Connect (OCC) 30-day deeming period, and noted that DHCS is now requiring health plans to extend the deeming period to two months. Ms. Khamseh also updated the PAC on the non-medical transportation benefit that became effective July 1, 2017 for CalOptima Medi-Cal members. Ms. Khamseh noted that a Request for Proposal (RFP) process will be conducted in the near future for non-medical transportation services. Ms. Khamseh also discussed Medi-Cal Client Index Numbers (CIN) for newborns. She noted that the State considers the mother's Medi-Cal eligibility to cover the newborn for the month of birth and the month afterward, unless the newborn is assigned its own CIN number.

Chief Medical Officer Update

Richard Helmer, M.D., Chief Medical Officer, discussed Senate Bill 1004 on Palliative Care that would mandate that palliative care be implemented in Medi-Cal plans. He also noted that there would be no additional payment received from the State. CalOptima is currently working to insure that we meet regulatory requirements and will continue to work with the networks and hospitals before the January 1, 2018 implementation date.

Back to Agenda

Dr. Helmer updated the members on the process to allow for the credentialing of optometrists who are not contracted with VSP. Dr. Helmer noted that an internal ad hoc to review payment methodology to insure CalOptima is paying Optometrists properly. Member Nishimoto, a practicing optometrist volunteered to serve on the ad hoc based on his role as a Non-Medical Practitioner.

Dr. Helmer also discussed the Request for Information (RFI) that was recently released for PACE Alternative Care Settings to evaluate expanding PACE countywide, and responses are being clarified. In addition, an RFI for perinatal support services is being finalized for release to identify capabilities in the county. Dr. Helmer also noted that a Pay For Value (P4V) program is being developed for the CalOptima Community Network (CCN).

Chief Financial Officer Update

Nancy Huang, Interim Chief Financial Officer, presented CalOptima's Financial Summary as of June 2017, including a report of the Health Network Enrollment for the month of June 2017. Ms. Huang summarized CalOptima's financial performance and current reserve levels.

Federal and State Budget Update

Arif Shaikh, Director, Government Affairs, provided updates on Congressional activities around the reauthorization of funding for the Children's Health Insurance Program (CHIP), as well as the reauthorization of Dual Eligible Special Needs Plans (D-SNPs). Mr. Shaikh noted that approximately 110,000 CalOptima members are impacted by CHIP funding, and the reauthorization of the program is critical to ensure financial sustainability for the state. CHIP funding is authorized through September 2017; D-SNPs are authorized by Congress through the end of 2018. CalOptima currently has approximately 1,200 dual-eligible seniors enrolled in its D-SNP, OneCare.

Cheryl Meronk, Director, Strategic Planning, presented an overview of the approved Intergovernmental Transfer (IGT) Funds, and the most recent Board approved funding categories for IGT 6 and 7. IGT 6 and 7 funds will be used to deliver enhanced services for the Medi-Cal population, in the primary categories of opioid and other substance overuse, children's mental health, homeless health, and community grants to support program areas beyond those funded by IGT 5. Proposed expenditure plans will be presented to the Board after receiving input from the PAC and other stakeholder groups.

INFORMATION ITEMS

Program Implementation Updates

Candice Gomez, Executive Director, Program Implementation, presented an update the status of various programs that were recently implemented or are in the process of being implemented. Ms. Gomez noted that the County-led Whole Person Care started on July 1, 2017. This program increases the coordination of physical, behavioral health and social services for CalOptima members who are homeless or have a behavioral health condition and are at risk of being homeless. Services include recuperative care, housing support services and mental health

services. Ms. Gomez also noted that Palliative Care is slated to take effect on January 1, 2018. The Health Homes Program and the Whole Child Model are anticipated to begin on January 1, 2019.

HEDIS 2017 Results

Kelly Rex-Kimmet, Director, Quality Analytics, presented the annual HEDIS results for 2017 and noted that CalOptima met all Department of Health Care Services (DHCS) minimum performance levels.

PAC Member Information

Chair Miranti reminded the PAC members that the September 14, 2017 meeting would be a joint meeting with the Member Advisory Committee (MAC). She asked the members to review the draft agenda in their folders and provide any additional topic recommendations.

ADJOURNMENT

There being no further business before the Committee, Chair Miranti adjourned the meeting at 10:03 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: October 12, 2017

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MINUTES

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

October 12, 2017

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, October 12, 2017, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Miranti, PAC Chair, called the meeting to order at 8:07 a.m., and Member Pham led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Teri Miranti, Chair; Suzanne Richards, MBA, FACHE, Vice Chair; Anjan Batra, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Alan Edwards, M.D.; Steve Flood; Jena Jensen; Pamela Kahn, R.N.; Craig G. Myers; George Orras, Ph.D., FAAP; Mary Pham, Pharm.D, CHC; Pamela Pimentel, R.N.; Jacob Sweidan, M.D.

Members Absent: John Nishimoto, O.D.

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Nancy Huang, Interim Chief Financial Officer; Candice Gomez, Executive Director, Program Implementation; Michelle Laughlin, Executive Director, Network Operations; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Tracy Hitzeman, Executive Director, Clinical Operations; Edwin Poon, PhD, Director, Behavioral Health Services; Sandeep Mital, Manager, Quality Initiatives; Cheryl Simmons, Staff to the Provider Advisory Committee

MINUTES

Approve the Minutes of the August 10, 2017 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Vice Chair Richards, seconded and carried, the Committee approved the minutes of the August 10, 2017 meeting. (Motion carried 14-0-0; Member Nishimoto absent)***

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Approve the Minutes of the September 14, 2017 Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee and the Provider Advisory Committee

Action: ***On motion of Member Pimentel, seconded and carried, the Committee approved the minutes of the September 14, 2017 meeting. (Motion carried 14-0-0; Member Nishimoto absent.)***

PUBLIC COMMENTS

No requests for public comment were received.

CEO AND MANAGEMENT REPORTS

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, gave a brief update on the behavioral health Medi-Cal transition from Magellan Healthcare and noted that CalOptima is holding daily meetings and moving forward with hiring staff necessary for this transition. Ms. Khamseh also briefly discussed the continuing interest in some quarters in considering the possibility of CalOptima in obtaining a Knox-Keene License for medical even though this license is not a requirement for County Organization Health System (COHS) plans. She also noted that CalOptima is considering establishing an Independent Medical Reviews (IMR) process.

Chief Medical Officer Update

Richard Bock, M.D., Deputy Chief Medical Officer, announced that for the fourth year in a row, CalOptima was again rated California's top Medi-Cal plan, according to the National Committee for Quality Assurance (NCQA) Plan Ratings 2017-2018.

Dr. Bock introduced Sandeep Mital, Manager of Quality Analytics, who gave a verbal report on the Data Collection workgroup that was created to help solve data issues related to the Pay for Value (P4V) and Healthcare Effectiveness Data and Information Set (HEDIS) programs. The health networks and CalOptima are collaborating to ensure all data is captured including the State's California Immunization Registry (CAIR).

Chief Financial Officer Update

Nancy Huang, Interim Chief Financial Officer, presented CalOptima's draft Financial Summary as of August 2017, including a report of the Health Network Enrollment for the month. Ms. Huang summarized CalOptima's financial performance and current reserve levels.

Network Operation Update

Michelle Laughlin, Executive Director Network Operations, provided an update on the Magellan transition, with the goal to retain the majority of providers for Applied Behavior Analysis (ABA) and Behavioral Health services. Ms. Laughlin also noted that Magellan will be returning the behavioral health member telephone number to CalOptima. This telephone number is noted on CalOptima member Medi-Cal cards, so continuing to use this number will help to make the upcoming transition seamless.

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Federal and State Budget Update

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, provided an update on the Children's Health Insurance Program (CHIP), and noted that a reauthorization was signed in to law in 2015, which funded CHIP through September 30, 2017. The current funding is split between Federal and State at 88% and 12%, respectively. Mr. Tsunoda discussed the various scenarios under consideration to fund the CHIP program

INFORMATION ITEMS

Behavioral Health Update

Edwin Poon, PhD, Director, Behavioral Health Services, presented a follow up to Sandra Fair's Drug Medi-Cal presentation at the September Joint MAC/PAC meeting, noting that 37% of the total referrals are for Alcohol and Drug Residential services, 17% for outpatient behavioral health therapy, and 50% for Magellan (mild to moderate) therapy services.

Whole Child Care Model

Candice Gomez, Executive Director, Program Implementation, provided a status on the transition plan for the Whole Child Care Model effective January 1, 2019. PAC members had questions regarding the provider network and the reimbursement after the program transitions to CalOptima. PAC members also questioned what the definition of Community Based Organization (CBO) was for the two seats that will serve on the new advisory committee that will be formed for the California Children's Services (CCS) program.

Palliative Care Update

This presentation was continued to the November 2017 meeting.

PAC Member Information

Chair Miranti reminded the PAC members that the next meeting is scheduled for November 9, 2017 and that the first quarter goals and objectives will be reviewed at that meeting. She also reminded the PAC members that mandatory compliance training must be completed by November 3, 2017.

ADJOURNMENT

There being no further business before the Committee, Chair Miranti adjourned the meeting at 10:00 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: November 9, 2017

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MINUTES

REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' ONECARE CONNECT CALMEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE

July 27, 2017

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on July 27, 2017, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Gio Corzo called the meeting to order at 3:09 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Gio Corzo, Chair; Patty Mouton, Vice Chair; Ted Chigaros, Christine Chow, Josefina Diaz, Sandy Finestone, Sara Lee, Richard Santana, Erin Ulibarri (non-voting)
Members Absent:	John Dupies, Adam Crits, M.D. (non-voting)
Others Present:	Ladan Khamseh, Chief Operating Officer; Phil Tsunoda, Executive Director, Public Affairs; Candice Gomez, Executive Director, Program Implementation; Tracy Hitzeman, Executive Director, Clinical Operations; Dr. Donald Sharps, Medical Director; Dr. Fonda, Medical Director; Caryn Ireland, Executive Director, Quality Analytics; Sesha Mudunuri, Executive Director, Operations; Customer Service; Belinda Abeyta, Director, Customer Service; Becki Melli, Customer Service; Eva Garcia, Administrative Assistant

Chair Corzo welcomed new OCC MAC member Richard Santana, In-Home Supportive Services (IHSS)/Union Provider Representative.

MINUTES

Approve the Minutes of the June 22, 2017 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Member Patty Mouton, seconded and carried, the OCC MAC approved the minutes as submitted.***

PUBLIC COMMENT
There were no requests for public comment.

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CEO AND MANAGEMENT TEAM DISCUSSION

Federal and State Budget and Legislative Update

Phil Tsunoda, Executive Director, Public Affairs, reported on the Congressional health care reform efforts. The Senate approved a "Motion to Proceed" on the Better Care Reconciliation Act (BCRA). Subsequently, the Senate rejected BCRA and related amendments by Sens. Cruz and Portman by a 43–57 vote, and then rejected the "Repeal Now, Replace Later" amendment by Sen. Paul 45–55.

INFORMATION ITEMS

OCC MAC Member Updates

Chair Corzo announced that the recruitment for the OneCare Connect member/family member representative ends on July 28, 2017. Members Sandy Finestone, Ted Chigaros and Christine Chow agreed to serve on the Nominations Ad Hoc Subcommittee to review the applications.

Member Sara Lee will present the Quarterly Ombudsman update at the August 24, 2017 meeting. Member Patty Mouton will present the OCC MAC presentation at the September 28, 2017 meeting.

OCC MAC Member Presentation – Post Acute 101

Member Ted Chigaros, Rockport Healthcare Services, presented an overview on post-acute care and skilled nursing facilities (SNFs), and the process that an OneCare Connect member undergoes to be admitted to and discharged from a SNF.

Member Chigaros brought up end-of-life matters in SNFs, which elicited discussion from OCC MAC members. Vice Chair Mouton asked about the use of Physician Orders for Life-Sustaining Treatment (POLST) forms within SNF's and by CalOptima providers. CalOptima staff will provide information on advance directives for discussion at a future OCC MAC meeting.

Behavioral Health and Geropsychiatric Bed Update

Donald Sharps, M.D., Medical Director, Behavioral Health, presented an update on how to access behavioral health benefits for Medi-Cal and OneCare Connect members. In addition, he provided an overview on access to geropsychiatric beds in Orange County, which is a psychiatric unit that specializes in treating seniors with psychiatric conditions as well as managing concurrent medical conditions. Following a robust discussion about accessing behavioral health services, CalOptima staff agreed to provide additional information at a future meeting.

Community Engagement

Cheryl Meronk, Strategic Development Director, provided an overview on CalOptima's approach to community engagement. CalOptima's community engagement efforts seek to create and maintain a positive influence and impact in the community by strengthening our community

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partnerships, which includes approximately 350 community organizations. In addition, CalOptima attends approximately 130 community meetings and collaborative events and provides more than $45,000 in community sponsorships annually.

CalOptima OneCare Connect (OCC) New Member Orientation (NMO)

Cynthia Valencia, Supervisor, Customer Service, presented an overview of the New Member Orientation (NMO) for new and existing OCC members. Ms. Valencia explained the purpose of the NMO includes the following: 1) to provide CalOptima members with an overview of their benefits; 2) to select a primary care provider; 3) to learn how to access services; and 4) to learn about member rights. In addition, OCC members have an opportunity to receive one-on-one assistance at the NMO.

ADJOURNMENT

Chair announced that the next OCC MAC Meeting is Thursday, August 24, 2017.

Hearing no further business, the meeting adjourned at 4:56 p.m.

/s/ Eva Garcia
Eva Garcia
Program Assistant

Approved: October 26, 2017

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MINUTES

REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' ONECARE CONNECT CALMEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE

October 26, 2017

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on October 26, 2017, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Gio Corzo called the meeting to order at 3:29 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Gio Corzo, Chair; Patty Mouton, Vice Chair; Ted Chigaros, Christine Chow, Josefina Diaz, Sandy Finestone, Sara Lee, Richard Santana, Erin Ulibarri (non-voting)

Members Absent: John Dupies; George A. Crits, M.D. (non-voting)

Others Present: Ladan Khamseh, Chief Operating Officer; Greg Hamblin, Chief Financial Officer; Dr. Bock, Chief Medical Officer; Sesha Mudunuri, Executive Director, Operations; Phil Tsunoda, Executive Director, Public Affairs; Candice Gomez, Executive Director, Program Implementation; Tracy Hitzeman, Executive Director, Clinical Operations; Dr. Fonda, Medical Director; Belinda Abeyta, Director; Becki Melli, Customer Service; Eva Garcia, Program Assistant

Ladan Khamseh, Chief Operating Officer, introduced CalOptima's new Chief Financial Officer, Greg Hamblin.

MINUTES

Approve the Minutes of the July 27, 2017 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Member Sandy Finestone, seconded and carried, the OCC MAC approved the minutes as submitted.***

PUBLIC COMMENT

There were no requests for public comment.

REPORTS

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Approve the Recommendation of Agency-Appointed Representatives from Social Services Agency (SSA) and Orange County In-Home Supportive Services Public Authority (IHSS PA)

Action: ***On motion of Member Patty Mouton, seconded and carried, the recommendation of agency-appointed representatives Jyothi Atluri (SSA) and Amber Nowak (IHSS PA) were approved.***

Approve the Recommendation of the OneCare Connect Member/Family Member Representative

Action: ***On motion of Member Patty Mouton, seconded and carried, the recommendation of the OneCare Connect Member/Family Representative Kristin Trom was approved.***

Approve Amendment to the OneCare Connect Member Advisory Committee Meeting Schedule for Remainder of Fiscal Year 2017/2018

Action: ***On motion of Member Patty Mouton, seconded and carried, the recommendation to amend the OneCare Connect Member Advisory Committee meeting schedule to bimonthly beginning in January 2018 for remainder of Fiscal Year 2017/2018 was approved.***

Chair Gio Corzo reordered the agenda to hear item VIII.B.

POLST in Orange County Challenges and Best Practices

Dr. Nguyen, Palliative Program Director, Hoag Hospital, presented the challenges and best practices of Physician Orders for Life-Sustaining Treatment (POLST) in Orange County. Dr. Nguyen reported that most people do not have an Advanced Health Care Directive and less than 25% have committed their end of life wishes in writing. He added that the majority of health care expenditures are incurred in the last month of life. Dr. Nguyen reported that a pilot project comparing hospital utilization between those with non-completed vs. completed POLSTs showed decreased hospital admissions for those with a completed POLST. These findings led to a concerted community education effort from July 2015 to June 2016 to increase awareness of the need for advanced care planning. The POLST Coalition learned that increased awareness and discussion resulted in increased POLST action planning. Dr. Nguyen cited the following three lessons learned: 1) advanced care planning is a continuous process; 2) gaps in successful engagement can be narrowed through education, motivation and empowerment; and 3) support from healthcare systems, health leaders and community advocates is essential.

Member Patty Mouton requested an agenda item at the next OCC MAC meeting on how palliative care services are being delivered and what processes are in place for CalOptima members.

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PRESENTATION

Orange County's Older Adult Health Improvement Plan

Dr. Calvet, Orange County Deputy Health Officer, Health Care Agency, presented on Orange County's efforts to improve older adult health. Dr. Calvet explained that the Orange County Healthy Aging Initiative (OCHAI), formed in 2013, is a collaboration of representatives from County agencies, universities, health care organizations and non-governmental organizations. OCHAI developed resources on older adult health and through community-based efforts developed the Orange County Community Health Improvement Plan (CHIP), Older Adult Health. The goal is to improve wellness and quality of life of older adults in Orange County through the following two objectives: to increase early identification of conditions and safety risks that commonly affect older adults by promoting the Annual Wellness Visit (AWV) and to reduce complications of chronic diseases by promoting chronic disease self-management.

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Medical Officer (CMO) Update

Dr. Bock, Chief Medical Officer, reported that CalOptima is continuing the behavioral health transition plan integrating the administration of Medi-Cal covered behavioral health benefits into CalOptima internal operations, effective January 1, 2018. CalOptima will continue to work with Magellan for members with Medicare.

Dr. Bock reported that CalOptima received commendable accreditation from the National Committee for Quality Assurance (NCQA) and was rated the top Medi-Cal managed care plan in California.

Dr. Bock will be presenting on opioid usage at a forum at the University of California, Irvine. The presentation will address how CalOptima has reduced the use of opioids, including the number of prescriptions, the percent of CalOptima's population on opioids and the percent taking high dosages of opioids. In addition, CalOptima has restricted prescriptions given by dentists and restricted the quantity of pills in each prescription.

Dr. Bock reported that the results from Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and member experience data will be shared with the health networks, including comparisons on how they rated to the other networks.

Federal and State Legislative and Budget Update

Cheryl Meronk, Director, Strategic Development, reported that CalOptima is requesting Letters of Interest (LOIs) from organizations to fund Community Grant Initiatives (Intergovernmental Transfers 6 and 7). As approved by the CalOptima Board of Directors, funding will address community needs in one or more of the following three priority areas, including: 1) opioid and other substance overuse; 2) homeless health; and 3) children's mental health. Information from

the LOIs will help determine grant funding allocation amounts for the three priority areas. Each LOI should be no more than 1,600 words and must be received by 5 p.m., Monday, November 13, 2017.

INFORMATION ITEMS

MAC Member Updates

Chair Corzo reminded OCC MAC members to complete the required Compliance training by Friday, November 3, 2017.

Member Sara Lee is scheduled to present the Quarterly Ombudsman update at the November 16, 2017 meeting.

CalOptima Cultural and Linguistics Services Overview

Carlos Soto, Manager, Cultural and Linguistics Services (C&L), explained that CalOptima's C&L provides and ensures effective communication to members in their language, including no-cost translation services in all threshold languages, member materials in alternative formats, such as Braille, large font or audio, and no-cost interpreter services. Mr. Soto reported that C&L provides communication services through the following goals and objectives: 1) conduct Awareness and Education Seminars on a quarterly basis; 2) provide staff with C&L in-service training regarding information and resources on cultural needs; 3) provide new staff with C&L training, including information on cultural concerns; 4) translate and review written member informing materials at no-cost in the members' preferred language to comply with mandated regulatory requirements; 5) translate the Annual Notice of Change member materials in all threshold languages; 6) provide no-cost, twenty-four hour access to interpretative services at key points of contact; and 7) publish C&L availability information in CalOptima's member newsletters.

ADJOURNMENT

Chair Corzo announced that the next OCC MAC meetings are scheduled for Thursday, November 16, 2017 and December 14, 2017.

Hearing no further business, the meeting adjourned at 4:36 p.m.

/s/ Eva Garcia
Eva Garcia, Program Assistant

Approved: November 16, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
3. Consider Approval of the Annual Investment Policy for Calendar Year 2018

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

Recommended Action
Approve the Annual Investment Policy (AIP) for Calendar Year (CY) 2018.

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

At the December 1, 2016, meeting, the Board approved the extension of the current AIP for CY 2017. Upon completion of the internal administrative policy review process, Management would present the revised AIP for CY 2017 to the IAC for review and approval.

On February 6, 2017, Staff completed the internal administrative policy review process.

Discussion
Payden & Rygel, Logan Circle Partners, and Wells Capital Management, CalOptima's investment managers, and Meketa Investment Group, Inc., CalOptima's investment adviser submitted proposed revisions to the AIP for CY 2018. Staff has reviewed the proposed revisions and recommends the following changes upon Board approval:

- Section III.D.2.b.ii.m. and n.: Delete Temporary Liquidity Guarantee (TLG) Program securities and Temporary Corporate Credit Union Liquidity Guarantee Program (TCCULGP) securities from the list of permitted investments with U.S. Government related organizations, as both programs expired.

- Section III.D.1.c.: Add language that prohibits private placement (144a) securities as a permitted investment.

- Sections III.E.3.c. and m.: Revise the maximum holding percentages for State and California Local Agency Obligations from 25% to 30% and Supranational Obligations from 15% to 30%. The increase to the holding percentages fall within the allowable limit under California Government Code section 53600 et seq.

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- Management recommends all other provisions in the current AIP remain in effect in CY 2018.

In addition to the proposed changes noted above, the attached red-lined version of the AIP for CY 2018 reflects non-substantive edits that were noted during the review process, as well as other formatting revisions intended to align the AIP with CalOptima's policy and procedure template.

Fiscal Impact
There is no immediate fiscal impact.

Rationale for Recommendation
The proposed changes to the AIP for CY 2018 reflect the recommendations of CalOptima's investment managers, Payden & Rygel, Logan Circle Partners, and Wells Capital Management and concurrence by CalOptima's investment adviser, Meketa Investment Group, Inc. These recommended changes continue to support CalOptima's goals to maintain safety of principal, and achieve a market rate of return while maintaining necessary liquidity during periods of uncertainty. Per the review conducted by Meketa Investment Group, Inc., there were no changes in the California Government Code affecting local agencies noted for the CY 2018.

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

Attachment
Draft Policy GA.3400, Annual Investments

/s/ Michael Schrader — *11/30/2017*
Authorized Signature — **Date**

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Policy #:	GA.3400
Title:	**Annual Investments**
Department:	Finance
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	TBD
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

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

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

a. The performance benchmark for each investment portfolio shall be based upon published market indices for short-term investments of comparable risk and duration.

i. These performance benchmarks shall be reviewed monthly by CalOptima's Treasurer and the Investment Managers and shall be approved by the Board of Directors.

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

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

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

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

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

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

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

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

III. PROCEDURE

A. Delegation of Authority

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

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

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

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

B. CalOptima Treasurer Responsibilities

1. The Treasurer shall be responsible for:

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

b. The oversight of CalOptima's investment portfolio;

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

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

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

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

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

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

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

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

C. Investment Advisory Committee

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

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

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

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

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

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

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

D. Permitted Investments

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

a. Permitted investments under the Operating Funds, unless otherwise specified, are subject to a maximum stated term of four hundred fifty (450) days. Note that the Code allows for up to five (5) years.

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

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

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

2. Permitted investments shall include:

a. U.S. Treasuries

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

ii. U.S. Government securities include:

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

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

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

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

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

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

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	450 days	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

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

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

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

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

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

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

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

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	450 days	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

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

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or equivalent or better for short-term obligations, or A by Moody's, or A by Standard & Poor's, or better, for long-term debt. Public agency bonds issued for private purposes (e.g., industrial development bonds) are specifically excluded as permitted investments.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	450 days	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

d. Banker's Acceptances

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

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

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

ii. Maximum Term:

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

e. Commercial Paper (CP)

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

a) Rated P-1 by Moody's, or A-1, or better, by Standard & Poor's;

b) Have an A, or higher, rating for the issuer's debt, other than CP, if any, as provided for by Moody's, or Standard & Poor's;

c) Issued by corporations organized and operating within the United States and having total assets in excess of five hundred million dollars ($500,000,000) or by corporations organized within the U.S. as special purpose corporations, trusts, or LLCs, which have program-wide credit enhancements, including but not limited to, overcollateralization, letter of credit, or a surety bond, and have commercial paper that is rated "A-1" or higher, or the equivalent, by a nationally recognized statistical rating agency; and

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

ii. Maximum Term:

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

f. Negotiable Certificates of Deposit

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

ii. Maximum Term:

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

g. Repurchase Agreements

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

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

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

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

d) The Agent will notify CalOptima's custodian and CalOptima if the valuation of the collateral securities falls outside of policy. Upon direction by the CalOptima Treasurer, the Agent will liquidate the collateral securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such valuation.

ii. Maximum Term:

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

iii. Reverse repurchase agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible corporate securities shall be rated "A" or better by Moody's, Standard & Poor's, or Fitch Ratings Service and:

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

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

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

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	450 days	5 years
Board-Designated Reserve Funds		
▪ Tier One (1)	5 years	5 years
▪ Tier Two (2)	5 years	5 years

i. Money Market Funds

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

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

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

j. Joint Powers Authority Pool

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

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

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

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

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

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

iv. Maximum Term:

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

k. Mortgage or Asset-backed Securities

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

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

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

a) Are rated AA- by a nationally recognized rating service; and

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

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	450 days	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years stated final maturity 5 years stated final maturity	 5 years 5 years

l. Variable and Floating Rate Securities

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

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

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

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

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

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

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

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

iii. Maximum Term:

Fund Type	**Term Assigned**	**Term Allowed by the Code**
Operating Funds	450 days	5 years
Board-Designated Reserve Funds		
▪ Tier One (1)	5 years	5 years
▪ Tier Two (2)	5 years	5 years

m. Supranational Obligations

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

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

b) International Finance Corporation (IFC); and

c) Inter-American Development Bank (IADB).

ii. Supranational obligations shall be rated AA by two (2) of the three (3) largest nationally recognized rating services.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	450 days	5 years
Board-Designated Reserve Funds		
▪ Tier One (1)	5 years	5 years
▪ Tier Two (2)	5 years	5 years

n. Pooled Investments

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

E. Diversification Guidelines

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

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

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

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

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

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

ii. Any one repurchase agreement counterparty name:

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

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

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

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

i. If one (1) Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform CalOptima's Treasurer and Investment Advisor (if any) by close of business on the day of the occurrence.

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

a) The context of the amount in relation to the total portfolio concentration;

b) Market and security specific conditions contributing to a breach of this Policy; and

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

F. Maximum Stated Term

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

G. Rating Downgrades

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

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

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

H. Investment Restrictions

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

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

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

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

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

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

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

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

A. None to Date

VII. BOARD ACTIONS

A. 11/16/17: Regular Meeting of the CalOptima Finance Advisory Committee
B. 12/03/15: Regular Meeting of the CalOptima Board of Directors
C. 03/05/15: Regular Meeting of the CalOptima Board of Directors
D. 06/05/14: Regular Meeting of the CalOptima Board of Directors
E. 12/05/13: Regular Meeting of the CalOptima Board of Directors
F. 01/03/13: Regular Meeting of the CalOptima Board of Directors
G. 10/04/12: Regular Meeting of the CalOptima Board of Directors
H. 01/06/11: Regular Meeting of the CalOptima Board of Directors
I. 08/05/10: Regular Meeting of the CalOptima Board of Directors
J. 12/04/08: Regular Meeting of the CalOptima Board of Directors
K. 12/07/04: Regular Meeting of the CalOptima Board of Directors
L. 01/07/03: Regular Meeting of the CalOptima Board of Directors

M. 01/11/00: Regular Meeting of the CalOptima Board of Directors
N. 03/03/98: Regular Meeting of the CalOptima Board of Directors
O. 02/04/97: Regular Meeting of the CalOptima Board of Directors
P. 02/27/96: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	TBD	GA.3400	Annual Investments	Administrative

IX. GLOSSARY

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

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

Term	Definition
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Board of Directors with oversight responsibilities for all financial matters of CalOptima including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial instrument or asset that can be traded. These assets can be cash, bonds, or shares in a company
Investment Advisors	Members of CalOptima Investment Advisory Committee (IAC).
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Board of Directors who provide advice and recommendations regarding the organization’s investments.
Investment Managers	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the underlying pool of securities owned by the joint powers authority.
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.

Term	Definition
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).
Market Risk	The risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CalOptima to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent CalOptima's monthly capitation revenues from its State contracts. Disbursements from this fund to CalOptima's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency (California Government Code, Section 53600.3)
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any capital gains realized on the sale of the investment.
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.

Term	Definition
State and California Local Agency Obligations	Registered state warrants, treasury notes or bonds of any U.S. state and bonds, notes, warrants, or other evidences of indebtedness of any local agency of the State of California, including bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial instrument or asset. CalOptima's asset managers provide CalOptima with reporting that shows the valuation of each financial instrument that they own on behalf of CalOptima. Each asset manager uses a variety of market sources to determine individual valuations.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
4. Consider Appointment to the CalOptima Board of Directors' Investment Advisory Committee

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

Recommended Action
Appoint Susan Munson for a two-year term to fill the current vacancy on the CalOptima Board of Directors' Investment Advisory Committee (IAC) effective December 7, 2017.

Background
At a Special Meeting of the CalOptima Board of Directors held on September 10, 1996, the Board authorized the creation of the IAC, established qualifications for committee members, and directed staff to proceed with the recruitment of the volunteer members of the Committee. IAC members do not make recommendations on individual investments. However, their role is to make recommendations to the Finance and Audit Committee (FAC) on changes to the Annual Investment Policy (AIP), and to monitor the performance of CalOptima's investments, investment advisor and investment managers.

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

At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five (5) members to seven (7) members in order to have more diverse opinions and backgrounds to advise CalOptima on its investment activities. The IAC currently has six members due to a recent committee member resignation triggered by a job relocation out of Orange County.

Discussion
As part of the process of filling the vacancy, CalOptima staff conducted a recruitment process intended to solicit a diverse applicant pool of candidates. The recruitment included an announcement on the CalOptima website, and advertisements in the local business journal and at academic institutions. Applications from two interested candidates were received and submitted them to the IAC Nominations Ad Hoc Committee for review and recommendations.

Prior to conducting on-site interviews on August 21, 2017, the Ad Hoc Committee members evaluated each of the applications submitted. Based on this process, the Ad Hoc Committee comprised of IAC

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Members Johnson, Young, and Huang, have made a recommendation and forwarded the recommended candidate to the IAC for consideration. The candidate recommended for appointment has proven leadership and expertise in finance and accounting.

Candidates:
David Hutchison
Susan Munson*

David Hutchison is a Partner at Triad Investment Management, LLC. He has over 17 years of experience in equity research and analysis, and investment management. Mr. Hutchison received his M.B.A. degree from the University of Southern California, and his B.A. degree from Macalester College.

Susan Munson is the Founder and CEO of Fixed Income Academy, an educational platform for financial professionals to learn about the bond market and develop their investment management skills. Ms. Munson has over 28 years of experience in finance and investment management, and is knowledgeable about the California Government Code provisions related to public agency investments. She has held positions at Merrill Lynch's Institutional Advisory Division, and continues to work closely with financial institutions, state and local governments, depositories and family offices to provide investor education. Ms. Munson frequently speaks and teaches at the Fixed Income Academy's Bond School and at national and regional conferences and workshops. She maintains her Certified Financial Planner (CFP®) designation, is a Certified Fixed Income Practitioner (CFIP), and is currently registered as an Investment Advisor Representative to provide advisory services to a small group of select clients.

Fiscal Impact
There is no fiscal impact. An individual appointed to the IAC would assist and advise CalOptima in safely maintaining an acceptable return on investment of available funds.

Rationale for Recommendation
The individual recommended for CalOptima's IAC has extensive experience that meets or exceeds the specified qualifications for membership on the IAC.

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

Attachment
None

/s/ Michael Schrader — *11/30/2017*
Authorized Signature — **Date**

*Indicates Nominations Ad Hoc Committee Recommendation

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
5. Consider Approval of Updates to Policy for Acceptable Use of Company-Issued Mobile Phones

Contact
Len Rosignoli, Chief Information Officer, 714-246-8400

Recommended Action
Approve proposed updates to policy GA.5005d: Acceptable Use of a Company-Issued Mobile Phone for Business Purposes.

Background/Discussion
CalOptima currently has a policy (GA.5005d) that defines the acceptable practices, responsibilities, and procedures for use of CalOptima-issued mobile phones, as well as the qualifications that must be met for an employee to receive and use a CalOptima-issued mobile phone. This policy, previously adopted January 1, 2014, is being updated as part of the standard periodic review process, and to bring it up to date based on current trends and information regarding information security and appropriate guidelines. The most significant proposed changes include:

- Incorporation of more stringent compliance guidelines within the policy itself
- Updated terminology (e.g. mobile phone vs. cellular phone)
- Additional clarity on what does and does not constitute acceptable business use (e.g. no personal use of the camera or video)
- Additional requirements for non-exempt employees to ensure compliance with applicable wage and hour laws (e.g. maintaining records of use after normal business hours)
- Additional monitoring, privacy and disclosure requirements consistent with applicable laws and CalOptima policies (e.g. no expectation of privacy on CalOptima-issued mobile phones and any text messaging may be subject to disclosure pursuant to a Public Records Act request)
- Incorporation of employee expectations to mitigate risk and liability (e.g. to comply with motor vehicle "hands-free" laws if using the mobile phone while operating a vehicle, to use appropriate caution when accessing PHI, etc.)

Fiscal Impact
Anticipated expenses related to company-issued mobile phones in FY 2017-18 total approximately $380,000 for carrier fees and accessories for 315 employees (approximately $100 per employee per month) and are included in the Board-approved budgeted item. There is no additional anticipated fiscal impact based on the proposed revisions to GA.5005d.

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

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Attachment

Policy GA.5005d, Acceptable Use of a Company-Issued Mobile Phone for Business Purposes, redlined and clean versions

/s/ Michael Schrader *11/30/2017*

Authorized Signature **Date**

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Policy #:	GA.5005d
Title:	~~Cellular Telephone Program~~Acceptable Use of a Company-Issued Mobile Phone for Business Purposes
Department:	Information Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/14
Last Review Date:	~~05/01/16~~ TBD
Last Revised Date:	~~05/01/16~~ TBD

I. PURPOSE

~~To define criteria for a CalOptima employee to qualify for a CalOptima-provided cellular telephone.~~

~~II. DEFINITIONS~~

This policy defines the accepted practices, responsibilities, and procedures for the use of a CalOptima-issued mobile phone for business purposes as well as the eligibility and commitment requirements, and provides guidance for the use of the CalOptima-issued mobile phone.

~~HelpDesk eTicket~~	~~The electronic ticketing system used at CalOptima.~~

~~III.~~II. POLICY

A. CalOptima has a ~~cellular telephone~~mobile phone program, whereby a qualifying employee may receive a CalOptima-~~provided cellular telephone~~issued mobile phone.

B. A qualifying employee is ~~any~~an employee, who ~~receives approval from their reporting Director or above and determines that a cellular telephone is needed~~, based on ~~the employees'~~his/her roles and responsibilities ~~and~~, is required to be in close contact with CalOptima at all times or requires access to a ~~cellular telephone~~mobile phone in order ~~for that employee~~ to perform ~~their~~his/her duties. Qualifying employees require the approval of both their reporting Executive Director or Chief, and the Human Resources Department, to ensure compliance with wage and hour laws and requirements.

C. Failure to comply with this policy and/or other applicable CalOptima policies regarding technology use may result in revocation of the privilege to have and use a CalOptima-issued mobile phone, and/or result in disciplinary action, up to and including termination.

~~C.~~D. An employee who receives a CalOptima-~~provided cellular telephone~~issued mobile phone shall:

1. ~~Use~~Only use the CalOptima-~~provided cellular telephone~~issued mobile phone to conduct ~~calls related to~~ CalOptima business;

2. Be ~~made~~ available for contact on the CalOptima-~~provided cellular telephone any time~~issued mobile phone during ~~the day including~~ business hours, as well as evenings and weekends, where designated or as-needed, for business-~~-~~related purposes;

3. Reasonably limit ~~their~~ use of the ~~company device~~CalOptima-issued mobile phone for personal business, except as it relates to the performance of ~~their~~ job responsibilities, (*e.g.*, communication to family due to company needed travel, offsite conferences, offsite work, etc~~.~~.). This includes not using the camera or video features for personal use;

4. Ensure all calls ~~made~~, messaging, and web access on the CalOptima-~~provided cellular telephone~~issued mobile phone are solely ~~for~~made from locations within the United States ~~and shall be held~~, unless previously approved for business purposes for a limited date range;

Use appropriate caution when accessing Protected Health Information (PHI) and ensuring that the device is not visible to others nearby;

5.

~~4.~~6. Be financially responsible for any calls made internationally~~.~~, unless previously approved for business purposes, or non-business-related charges incurred;

~~5.~~7. Not add, download, or purchase any applications or special features on the CalOptima-~~provided cellular telephone~~issued mobile phone that require a fee or are ~~in consistent~~inconsistent with the CalOptima Code of Conduct and applicable CalOptima policies and procedures;

~~6.~~8. Contact the Information Services (IS) Department immediately if the CalOptima-~~provided cellular telephone becomes lost or stolen. The qualifying employee may be subject to charges associated with the CalOptima provided cellular telephone or any lost device; and~~issued mobile phone is lost or stolen;

9. Accept that CalOptima work will be monitored for information security purposes and compliance with CalOptima policies and procedures;

10. Abide by applicable laws when using the mobile phone while operating a vehicle;

11. Return the CalOptima-~~provided cellular telephone~~issued mobile phone if the nature of their position changes, or upon ~~exit~~leaving employment with CalOptima;

12. Only update the operating system of the phone when directed by the IS Department;

~~7.~~13. Not be eligible for device upgrades unless determined by business need or approval from ~~CalOptima.~~the employee's Executive Director or Chief. An employee shall not assume that device upgrades will follow any specified timeline;

14. Prevent unauthorized use of the CalOptima-issued mobile phone;

15. Enable the "find phone" feature on the mobile phone; and

16. Keep detailed time records of each phone-related activity together with date, time of day, content description and actual duration of call, email, text message, etc. if the qualifying employee is a non-exempt employee.

E. Non-exempt qualifying employees who only need CalOptima-issued mobile phones during business hours, but not while off-duty, shall refrain from using the CalOptima-issued mobile phones during non-work hours, unless otherwise directed by the qualifying employee's supervisor, in conjunction with direction from the Human Resources Department regarding wage and hour requirements.

F. The use of the camera on the CalOptima-issued mobile phones, or other audio or video recording, may constitute an invasion of employees' personal privacy and may breach the confidentiality of CalOptima's trade secrets or other protected information. Therefore, the use of camera or other video/audio recording on CalOptima-issued mobile phones is prohibited without the express prior permission of the department Executive and of the person(s) present at the time.

G. Employees should have no expectation of privacy regarding the contents and data maintained on CalOptima-issued mobile phones, which may be subject to review and inspection at any time. Contents stored on CalOptima-issued mobile phones may be subject to disclosure under the Public Records Act.

H. Employees who cause a security breach, violate CalOptima's confidentiality policy, cause an accident by recklessly using their phones, or violate this policy may face disciplinary action, up to and including termination. CalOptima may seek criminal and/or civil remedies, where appropriate.

~~IV.~~III. PROCEDURE

A. CalOptima ~~provided cellular telephone~~issued mobile phone may be requested as follows:

1. Executives (above the Director Level) ~~–~~ Executives may submit a ~~HelpDesk eTicket~~help desk ticket to ~~the IS HelpDesk eTicket system making the~~ request ~~for~~ a CalOptima ~~provided cellular telephone. (~~issued mobile phone for him/herself. (An Executive ~~Administrative Assistants~~Assistant may also make this request on behalf of the Executive ~~Employee)~~employee.)

2. Directors - The ~~employee's next level reporting~~Director's Executive or Chief, as applicable, will submit a ~~HelpDesk eTicket~~help desk ticket to ~~the IS eTicket system making the~~ request on the ~~employees~~Director's behalf; their submission of this request will serve as their endorsement of the business need for the company device.

3. ~~Managers and below~~ Below Director-level exempt employees - The employee's Director, with the written approval of the Executive or Chief of the department, will submit a ~~HelpDesk eTicket to the IS HelpDesk eTicket system~~help desk ticket making the request on the ~~employees~~exempt employee's behalf; their submission of this request will serve as their endorsement of the business need for the company device.

4. Non-exempt employees – ~~In addition to the above signoff, the employees in this category will need~~ The employee's Director, with the written ~~endorsement~~ approval of the Executive or Chief of the department and the written approval from the Executive Director of HR~~.~~, will submit a

help desk ticket making the request on the non-exempt employee's behalf; their submission of this request will serve as their endorsement of the business need for the company device.

B. ~~B.~~ Once ~~Approved~~approved for the CalOptima-~~provided cellular telephone~~issued mobile phone, the employee shall:

1. Complete all required equipment release forms requested by the IS Department~~.~~;

2. Be professional and conscientious at all times when using CalOptima-issued mobile phones and shall take reasonable care of the CalOptima-issued mobile phones;

3. Return the CalOptima-issued mobile phone when requested or upon leaving employment with CalOptima;

4. Notify IS immediately, or within no more than twenty-four (24) hours of the phone being lost or stolen;

5. Report any security breach or Breach of PHI to the Office of Compliance immediately, but in no event more than twenty-four (24) hours of the incident.

~~2.~~ C. The IS Department will provide the approved requestor a CalOptima-~~provided cellular telephone~~issued mobile phone based on its current approved list of ~~cellular~~mobile devices and its corresponding plan.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Employee Handbook
C. CalOptima Policy IS.1001: Glossary of Terms

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Name
~~Original~~Effective	01/01/2014	GA.5005d	Cellular Telephone Program
Revised	04/01/2015	GA.5005d	Cellular Telephone Program

~~Poli~~ ~~cy~~Policy #: GA.5005d

Title: ~~Cellular Telephone Program~~Acceptable Use of a Company-Issued Mobile Phone for Business Purposes Revised Date: ~~05/01/16~~TBD

Version	Date	Policy Number	Policy Name
Revised	05/01/2016	GA.5005d	Cellular Telephone Program
Revised	TBD	GA.5005d	Acceptable Use of a Company-Issued Mobile Phone for Business Purposes

1

IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, First Tier, Downstream and Related Entities, and agents of CalOptima are expected to adhere.
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Policy #:	GA.5005d
Title:	**Acceptable Use of a Company-Issued Mobile Phone for Business Purposes**
Department:	Information Services
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	01/01/14
Last Review Date:	TBD
Last Revised Date:	TBD

I. PURPOSE

This policy defines the accepted practices, responsibilities, and procedures for the use of a CalOptima-issued mobile phone for business purposes as well as the eligibility and commitment requirements, and provides guidance for the use of the CalOptima-issued mobile phone.

II. POLICY

A. CalOptima has a mobile phone program, whereby a qualifying employee may receive a CalOptima-issued mobile phone.

B. A qualifying employee is an employee, who, based on his/her roles and responsibilities, is required to be in close contact with CalOptima at all times or requires access to a mobile phone in order to perform his/her duties. Qualifying employees require the approval of both their reporting Executive Director or Chief, and the Human Resources Department, to ensure compliance with wage and hour laws and requirements.

C. Failure to comply with this policy and/or other applicable CalOptima policies regarding technology use may result in revocation of the privilege to have and use a CalOptima-issued mobile phone, and/or result in disciplinary action, up to and including termination.

D. An employee who receives a CalOptima-issued mobile phone shall:

1. Only use the CalOptima-issued mobile phone to conduct CalOptima business;

2. Be available for contact on the CalOptima-issued mobile phone during business hours, as well as evenings and weekends, where designated or as-needed, for business-related purposes;

3. Reasonably limit use of the CalOptima-issued mobile phone for personal business, except as it relates to the performance of job responsibilities, (*e.g.*, communication to family due to company needed travel, offsite conferences, offsite work, etc.). This includes not using the camera or video features for personal use;

4. Ensure all calls, messaging, and web access on the CalOptima-issued mobile phone are solely made from locations within the United States, unless previously approved for business purposes for a limited date range;

5. Use appropriate caution when accessing Protected Health Information (PHI) and ensuring that the device is not visible to others nearby;

6. Be financially responsible for any calls made internationally, unless previously approved for business purposes, or non-business-related charges incurred;

7. Not add, download, or purchase any applications or special features on the CalOptima-issued mobile phone that require a fee or are inconsistent with the CalOptima Code of Conduct and applicable CalOptima policies and procedures;

8. Contact the Information Services (IS) Department immediately if the CalOptima-issued mobile phone is lost or stolen;

9. Accept that CalOptima work will be monitored for information security purposes and compliance with CalOptima policies and procedures;

10. Abide by applicable laws when using the mobile phone while operating a vehicle;

11. Return the CalOptima-issued mobile phone if the nature of their position changes, or upon leaving employment with CalOptima;

12. Only update the operating system of the phone when directed by the IS Department;

13. Not be eligible for device upgrades unless determined by business need or approval from the employee's Executive Director or Chief. An employee shall not assume that device upgrades will follow any specified timeline;

14. Prevent unauthorized use of the CalOptima-issued mobile phone;

15. Enable the "find phone" feature on the mobile phone; and

16. Keep detailed time records of each phone-related activity together with date, time of day, content description and actual duration of call, email, text message, etc. if the qualifying employee is a non-exempt employee.

E. Non-exempt qualifying employees who only need CalOptima-issued mobile phones during business hours, but not while off-duty, shall refrain from using the CalOptima-issued mobile phones during non-work hours, unless otherwise directed by the qualifying employee's supervisor, in conjunction with direction from the Human Resources Department regarding wage and hour requirements.

F. The use of the camera on the CalOptima-issued mobile phones, or other audio or video recording, may constitute an invasion of employees' personal privacy and may breach the confidentiality of CalOptima's trade secrets or other protected information. Therefore, the use of camera or other video/audio recording on CalOptima-issued mobile phones is prohibited without the express prior permission of the department Executive and of the person(s) present at the time.

G. Employees should have no expectation of privacy regarding the contents and data maintained on CalOptima-issued mobile phones, which may be subject to review and inspection at any time. Contents stored on CalOptima-issued mobile phones may be subject to disclosure under the Public Records Act.

H. Employees who cause a security breach, violate CalOptima's confidentiality policy, cause an accident by recklessly using their phones, or violate this policy may face disciplinary action, up to and including termination. CalOptima may seek criminal and/or civil remedies, where appropriate.

III. PROCEDURE

A. CalOptima-issued mobile phone may be requested as follows:

1. Executives (above the Director Level) – Executives may submit a help desk ticket to request a CalOptima-issued mobile phone for him/herself. (An Executive Assistant may also make this request on behalf of the Executive employee.)

2. Directors - The Director's Executive or Chief, as applicable, will submit a help desk ticket to request on the Director's behalf; their submission of this request will serve as their endorsement of the business need for the company device.

3. Below Director-level exempt employees - The employee's Director, with the written approval of the Executive or Chief of the department, will submit a help desk ticket making the request on the exempt employee's behalf; their submission of this request will serve as their endorsement of the business need for the company device.

4. Non-exempt employees – The employee's Director, with the written approval of the Executive or Chief of the department and the written approval from the Executive Director of HR, will submit a help desk ticket making the request on the non-exempt employee's behalf; their submission of this request will serve as their endorsement of the business need for the company device.

B. Once approved for the CalOptima-issued mobile phone, the employee shall:

1. Complete all required equipment release forms requested by the IS Department;

2. Be professional and conscientious at all times when using CalOptima-issued mobile phones and shall take reasonable care of the CalOptima-issued mobile phones;

3. Return the CalOptima-issued mobile phone when requested or upon leaving employment with CalOptima;

4. Notify IS immediately, or within no more than twenty-four (24) hours of the phone being lost or stolen;

5. Report any security breach or Breach of PHI to the Office of Compliance immediately, but in no event more than twenty-four (24) hours of the incident.

C. The IS Department will provide the approved requestor a CalOptima-issued mobile phone based on its current approved list of mobile devices and its corresponding plan.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Employee Handbook
C. CalOptima Policy IS.1001: Glossary of Terms

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Name
Effective	01/01/2014	GA.5005d	Cellular Telephone Program
Revised	04/01/2015	GA.5005d	Cellular Telephone Program
Revised	05/01/2016	GA.5005d	Cellular Telephone Program
Revised	TBD	GA.5005d	Acceptable Use of a Company-Issued Mobile Phone for Business Purposes

IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402.
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Pulled from Agenda 12/7/2017

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
6. Consider Ratification and Amendment of Contract with Housecall Doctors Medical Group

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

Recommended Actions
1. Ratify contract with Housecall Doctors Medical Group; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to Amend existing OneCare contract with Housecall Doctors Medical Group to include OneCare Connect Line of Business for Members in the CalOptima Community Network.

Background
Historically, home assessments have been administered to CalOptima members through various initiatives. In 2008, CalOptima's Board of Directors approved a pilot project to conduct home assessments of 150 institutionalized and homebound OneCare members and authorized contracting with a selected vendor to perform the assessments. Following the pilot, CalOptima staff contracted with Housecall Doctors Medical Group in September 2013 to provide home assessments to OneCare members as assigned. Assignments typically follow unsuccessful attempts by both CalOptima and the member's primary care provider (PCP) to contact the member, and a full year passing since the member's last provider visit. Staff has subsequently extended the contract on an annual basis, relying on the annual Board approval of all specialty provider contracts. Since 2013, the arrangement with Housecall Doctors has produced favorable results including robust patient assessments, positive reception by CalOptima members, and approximately 20 member health assessments completed per month.

In the intervening years, CalOptima's delivery system has changed significantly with the addition of the Coordinated Care Initiative, OneCare Connect (OCC), CalOptima Community Network (CCN), and an enhanced model of care. As a result, CalOptima has continued to increase the focus on improved health outcomes, quality of care, and clinical care in members' home and community settings. Frequent member contact and care coordination are key objectives of the current delivery model.

Additionally, the Centers for Medicare & Medicaid Services (CMS) now recognize home care visits as covered services under Medicare in support of care coordination. There have also been updates by creating procedural codes for home assessments. CMS has also developed related quality withhold measures such as encounters, documentation of care goals, and case management which are supported by completion of home assessments.

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In alignment with these changes and to continue best practices for appropriate assessment and access to care, staff is recommending amendment of the contract with Housecall Doctors to include the OneCare Connect line of business to cover similar situations when an extended period of time passes during which neither the PCP nor CalOptima staff are successful in contacting the member.

Discussion

Recent provider chart audits, claims data and encounters indicate there are approximately 160 OCC CCN members who have not seen a provider recently or who have incomplete medical documentation to support their conditions. This is a fragile population due to age, chronic health conditions and disabilities. These members may have barriers in accessing care or limitations in mobility. They may reside at their personal residence, in a long-term care facility or be homeless. Given difficulties in engaging these members, home assessments provide an essential alternative option for these members to obtain health care services.

Home assessments are intended to supplement and not replace the responsibilities of the member's PCP. The goal is to engage with members and support the PCP's care plan through complete health information and increased member visits. Home assessment providers provide a needed solution by delivering clinical care to vulnerable members in their preferred setting or circumstance who would otherwise not be receiving care. These Housecall Doctors providers are qualified providers who must meet credentialing requirements, are well known within the community, and have experience in providing care to CalOptima members. Given these providers' experience, they have processes for obtaining member consent and providing instructions for seamless delivery. They also produce comprehensive history and physicals, document HEDIS related findings, and may serve as a source of information for members who may otherwise run the risk of falling through the cracks.

As a contracted provider Housecall Doctors receives payment for each completed home assessment via submitted and processed claims. Reimbursement is based on Medicare fee-for-service (FFS) guidelines, care coordination codes, appropriate billing procedures.

In summary, frequent member contact and assessments are key to CalOptima's current delivery model which strives to serve and provide quality care to our members. Home assessments of members who would otherwise not receive care support the core objectives of CalOptima's model of care program and overall quality performance. Two of CalOptima's delegated health networks have established similar home assessment programs with positive outcomes. It would be beneficial to produce similar outcomes for CalOptima's Community Network

Fiscal Impact

The CalOptima Fiscal Year (FY) 2017-18 Operating Budget approved by the Board on June 1, 2017, included expenses related to home assessments for OneCare Connect members. Assuming the rates and terms of the existing and new contracts remain unchanged, the recommended action through June 30, 2018, is a budgeted item with a FY 2017-18 fiscal impact of $60,000 based on the projected utilization for the targeted OCC CCN population.

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Rationale for Recommendation

Amending the Housecall Doctors' contract to provide in-home physicals and plans of care to members who might otherwise not receive care are essential to ensuring quality care for CalOptima's OneCare and OneCare Connect members. The proposed actions may also support appropriate clinical documentation and improvements in quality measures. The proposed actions pertain to covered Medicare services and do not provide any greater extent of service or reimbursement than is currently allowed.

Concurrence

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

Attachments

1. Board Action dated September 4, 2008, Approve Pilot Project to Conduct Assessments of 150 Institutionalized and Homebound OneCare Members and Authorize the Chief Executive Officer to Enter into a Contract with a Selected Vendor to Implement the Project
2. Board Action dated December 4, 2008, Approve Project to Conduct Health Assessments on Certain Institutionalized OneCare Members and Authorize the Chief Executive Officer to Enter into a Contract with a Selected Vendor to Complete the Health Assessments

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

11/30/2017 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 4, 2008
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. D. Approve Pilot Project to Conduct Assessments of 150 Institutionalized and Homebound OneCare Members and Authorize the Chief Executive Officer to Enter into a Contract with a Selected Vendor to Implement the Project

Contact

Gertrude Carter, Chief Medical Officer, 714-246-8400

Recommended Actions

1. Approve a pilot project to conduct assessments on a subgroup of 150 institutionalized and homebound OneCare members; and,
2. Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into a contract with a selected vendor to implement the pilot project.

Background

CalOptima has tracked performance measures for its OneCare program since its inception. Performance has been based on industry standard measures such as Health Employer Data & Information Set (HEDIS), Hierarchical Condition Categories (HCCs), and encounter data analysis. Recent data analysis has demonstrated that a significant portion of the OneCare population has not accessed preventive services. Among members who may not consistently access the full range of covered preventive services are members who are institutionalized in skilled nursing facilities and those members who are homebound.

This pilot project aims to provide a health risk assessment to institutionalized and homebound members. A comprehensive risk assessment will appropriately identify HCC codes and enable the appropriate provision of preventive services, diagnostic testing and evidence-based care.

Discussion

The provision of timely health assessments is essential to provide coordinated care to special needs members such as the dual eligible members in OneCare. Since the members who are included in this pilot are institutionalized or homebound in addition to being special needs, the ability to bring the assessments to where the members reside is critical.

During the course of the pilot project, physicians trained to use the selected vendor's analytics will assess the member's medical and social service needs. As proposed, the pilot will include assessments of the approximately 100 institutionalized OneCare members, along with approximately 50 OneCare members identified as homebound. Based on this assessment, a comprehensive care plan will be developed. Components of the assessment will include a history and physical, mental status exam, functional status review, review of systems, personal and social history, and chart review. Information gathered from the assessment will be developed into a comprehensive care plan which will be coordinated with the member's primary care

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physician for implementation. This assessment does not replace the contracted physician groups' history and physical/assessment obligations. It is intended to ensure that all appropriate ICD-9s are identified for appropriate HCC coding. As contemplated, Leprechaun LLC, the proposed vendor, provides the analysis and will subcontract with Matrix and At Home Doctors to implement the pilot program.

Fiscal Impact

The vendor will receive payment of $350 for each assessment it completes. In addition, to the extent that additional HCCs are identified and included in the final CMS sweeps, the vendor will be paid an additional amount of up to $750 per member participating in the pilot. OneCare's FY08-09 budget includes funds of $165,000 for member assessment which, as proposed, will be used to fund the pilot program.

Rationale for Recommendation

The recommended actions will enable OneCare to provide health assessments to a vulnerable subset of OneCare's membership and to provide comprehensive information to implement an appropriate care plan.

Concurrence

Procopio, Cory, Hargreaves & Savitch LLP

Attachments

None

/s/ Richard Chambers — *8/28/2008*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2008
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

V. E. Approve Project to Conduct Health Assessments on Certain Institutionalized OneCare Members and Authorize the Chief Executive Officer to Enter into a Contract with a Selected Vendor to Complete the Health Assessments

Contact

Kurt Hubler, Executive Director of OneCare, 714-246-8400

Recommended Actions

1. Approve modification to a project to conduct health assessments on certain institutionalized OneCare members; and,
2. Authorize the Chief Executive Officer to enter into a contract with a selected vendor to implement the project.

Background

At its September 4, 2008 meeting, the CalOptima Board of Directors approved a pilot project to conduct health assessments on a subgroup of 150 institutionalized and home bound OneCare members. The Board also authorized the CEO to enter into a contract with Leprechaun LLC to implement the pilot project. However, subsequent to the Board approval of this pilot project, Leprechaun LLC informed CalOptima that it will not be able to complete the pilot project in 2008. Completion of the health assessments in 2008 is essential to the success of the project to ensure that the Hierarchical Condition Codes (HCC's) and Health Employer Data & Information Set (HEDIS) performance results are accurate for the 2008 calendar year.

Discussion

The provision of timely health assessments is essential to provide coordinated care to special needs members such as the dual eligible members in OneCare. OneCare has reviewed the encounter profiles of the current institutional members and have identified approximately 100 members that have insufficient medical encounters during the calendar year. To assure these members receive the appropriate assessment, OneCare has identified a provider—Housecall Doctors Medical Group—that can complete 50 – 100 health assessments in 2008. Based on these assessments, comprehensive care plans will be developed for assessed members.

Fiscal Impact

The selected vendors will receive payment of $210 for each assessment it completes. If assessments for 100 members are completed, that would total $21,000. OneCare's FY08-09 budget includes funding for this amount for member assessments.

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Rationale for Recommendation

The recommended actions will enable OneCare to provide health assessments to a vulnerable subset of OneCare's membership and to provide comprehensive information to implement appropriate, member-specific care plans.

Concurrence

Procopio, Cory, Hargreaves & Savitch LLP

Attachments

None

/s/ Richard Chambers — **Authorized Signature**

11/26/2008 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Consider Revision to the Fiscal Year (FY) 2017-18 Board of Directors' Quality Assurance Committee Meeting Schedule

Contact

Michael Schrader, Chief Executive Officer, (714) 246-8400

Recommended Action

Approve recommended revision to the adopted FY 2017-18 CalOptima Board of Directors Meeting Schedule to change the February 14, 2018 Board of Directors' Quality Assurance Committee (QAC) meeting date to February 20, 2018 at 3:00 p.m.

Discussion

On June 1, 2017, the Board of Directors adopted the FY 2017-18 schedule of meetings for the Board of Directors, Board of Directors' Finance and Audit Committee, and Board of Directors' Quality Assurance Committee through June 30, 2018. As adopted, the Board of Directors' Quality Assurance Committee meeting schedule reflects quarterly meetings at 3:00 p.m. on the third Wednesday in the months of September, November, February and May.

Due to conflicting schedules, the following revision to the QAC meeting schedule is requested:

- Revise the date of the meeting scheduled on Wednesday, February 14, 2018 at 3:00 p.m. to Tuesday, February 20, 2018 at 3:00 p.m.

Unless otherwise noticed, all QAC meetings will be held at CalOptima's offices located at 505 City Parkway West in Orange, California.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

The recommended action will revise the Board of Directors' FY 2016-17 Meeting Schedule as required in Section 5.2 of the Bylaws.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Proposed Revised FY 2017-18 Board of Directors' Meeting Schedule

/s/ Michael Schrader *11/30/2017*
Authorized Signature **Date**

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Board of Directors Meeting Schedule
July 1, 2017 – June 30, 2018

All meetings are held at the following location, unless notice of an alternate location is provided:

505 City Parkway West
Orange, California 92868

Board of Directors **Monthly – First Thursday** **Meeting Time: 2:00 p.m.**	**Finance and Audit Committee** **Quarterly – Third Thursday** **Meeting Time: 2:00 p.m.**	**Quality Assurance Committee** **Quarterly – Third Wednesday** **Meeting Time: 3:00 p.m.**
July 2017^		
August 3, 2017		
September 7, 2017	September 21, 2017	September 20, 2017
October 5, 2017		
November 2, 2017	November 16, 2017	November 15, 2017
December 7, 2017		
January 2018^		
February 1, 2018	February 15, 2018	February ~~14~~ 20, 2018
March 1, 2018		
April 5, 2018		
May 3, 2018	May 17, 2018	May 16, 2018
June 7, 2018[1]		

^No Regular meeting scheduled
[1] Organizational Meeting

Adopted June 1, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Ratification of the Extension of the Contract with Liberty Dental Plan of California, Inc., for Dental Services Provided to OneCare and OneCare Connect Members for the 2018 Calendar Year

Contact

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

Recommended Action

Ratify the extension of the Liberty Dental Plan of California, Inc. contract for OneCare and OneCare Connect (OCC) members for calendar year 2018 under the existing terms and conditions.

Background/Discussion

The OneCare Connect (OCC) program was launched by CalOptima on July 1, 2015. Prior to the implementation by CalOptima, the program was launched in six other counties via passive enrollment. These counties experienced a 49% pre-enrollment opt-out rate. Concerned about the high opt-out rate, CalOptima developed strategies to mitigate this trend in Orange County. At the April 2, 2015 Board of Directors meeting, approval was obtained to contract with a dental benefits administrator to provide supplemental benefits for OCC members effective July 1, 2015 to December 31, 2015. Although OCC members are eligible for Denti-Cal, in certain situations, access remained an issue and it was thought that a positive dental experience would motivate members to stay in OCC. With Board approval, CalOptima staff contracted with Liberty Dental Plan to administer and coordinate the supplemental dental benefits for OCC members.

At its December 3, 2015 meeting, the Board authorized staff to amend the Liberty Dental contract to add supplemental dental benefits for OneCare members and to extend the supplemental dental benefit for OCC members for the period January 1, 2016 through December 31, 2016, with two one-year options to extend at CalOptima's sole discretion.

CalOptima has exercised its second option to extend the contract for an additional year through December 31, 2018. Staff now requests the Board to ratify this extension as a number of open issues are being addressed. If these issues are not resolved in a timely manner, staff may be returning to the Board with further recommendations.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2017-18 Operating Budget approved by the Board on June 1, 2017, includes OneCare and OneCare Connect dental service expenses that were consistent with forecasted enrollment. Staff included approximately $1.4 million in the FY 2017-18 Operating Budget for dental service expenses. Since the rates and terms of the contract will not change, the recommended action to renew the contract with Liberty Dental for dental services from January 1, 2018, through June 30, 2018, is a budgeted item with no additional fiscal impact.

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Management will include expenses related to the contract extension for the period of July 1, 2018, through December 31, 2018, in the CalOptima FY 2018-19 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends Board approval of this action to ensure that OneCare and OneCare Connect members continue to have access to dental services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 3, 2015, Authorize Contract Amendments with Liberty Dental for Supplemental Dental Benefit for OneCare; Extend the Supplemental Dental Benefit OneCare Connect; and Authorized Deemed Eligibility for Members Receiving Denti-Cal.
2. Board Action dated April 2, 2015, Authorize Modifications to Member Assignment Process for OneCare Connect Program;

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

12. Authorize Contract Amendments with Liberty Dental for a Supplemental Dental Benefit for OneCare; Extend the Supplemental Dental Benefit for OneCare Connect; and Authorize Deemed Eligibility for Members Receiving Denti-Cal

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into contract amendments with Liberty Dental for supplemental dental benefits for:
    a. OneCare from January 1, 2016 through December 31, 2016, with two additional one year extension options, each exercisable at CalOptima's sole discretion
    b. OneCare Connect from January 1, 2016 through December 31, 2017; and
2. Authorize one month of deemed eligibility for OneCare Connect members receiving Denti-Cal services provided by Liberty Dental.

Background/ Discussion

In actions taken on April 2, 2015, the CalOptima Board of Directors authorized a supplemental dental benefit for the OneCare Connect program as well as funding and contracting with Liberty Dental. Voluntary enrollment into OneCare Connect has increased based on the additional supplemental dental benefits being offered by CalOptima in the program. The supplemental dental benefit provides services not covered by the Denti-Cal benefit. Staff believes the supplemental dental benefit has increased member retention in the program.

In order to keep the benefits similar to OneCare Connect, OneCare added the same supplemental dental benefit to the 2016 Centers for Medicare &Medicaid Services (CMS) approved OneCare bid.

At its August 6, 2015 meeting, the CalOptima Board of Directors authorized a one month deeming period for OneCare Connect Members who no longer met Cal MediConnect eligibility requirements due to loss of Medi-Cal eligibility with CalOptima. This benefit was added to mitigate breaks in coverage and maintain continuity of care for members. Management proposes a similar one month deeming period for Denti-Cal benefits for OneCare Connect members. Should a member fail to regain eligibility for the Medi-Cal program during the one month period of deemed eligibility, CalOptima would be financially responsible for the cost of the month of deemed eligibility. Based on the proposed action, eligibility for the one month of deemed dental benefits through Liberty Dental would be available through December 31, 2017 for OneCare Connect members.

Fiscal Impact

Based on the forecasted OneCare enrollment for Fiscal Year (FY) 2015-16, the fiscal impact of the recommended action to issue a contract amendment for the supplemental dental benefit for the OneCare Program from January 1, 2016, through June 30, 2016, is approximately $55,000. Costs associated with the recommended action were incorporated into Calendar Year 2016 OneCare capitation rate. Funding

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for the recommended action for the period July 1, 2016 through December 31, 2016, will be included in the FY 2016-17 CalOptima Consolidated Operating Budget.

Based on the forecasted OneCare Connect enrollment for FY 2015-16, the fiscal impact of the recommended action to issue a contract amendment for supplemental dental benefit for the OneCare Connect Program from January 1, 2016 through June 30, 2016, is approximately $445,000. This is a budgeted item under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015. Funding for the recommended action for the period July 1, 2016 through December 31, 2017, will be budgeted in subsequent operating budgets.

Projected expenses related to the provision of the deeming benefit are approximately $3,500 per month.

Rationale for Recommendation

CalOptima staff recommends supplemental dental services to OneCare Connect members to strengthen the programs ability to minimize pre-enrollment opt out, maximize post enrollment retention and strong provider participation in the program. OneCare members will continue to have the same CMS approved supplemental benefit as OneCare Connect members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Previous Board actions referenced in this Report Item:

- August 6, 2015, Agenda Item VIII. J., Authorize Actions Related to OneCare Connect Enrollment
- April 2, 2015, Agenda Item VIII. B., Authorize Modifications to Member Assignment Process for the OneCare Connect Program; Authorize Supplemental Dental Benefit for the OneCare Connect Program, as well as Funding and Contracting with a Vendor as Necessary to Implement

/s/ Michael Schrader *11/25/2015*

Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. B. Authorize Modifications to Member Assignment Process for the OneCare Connect Program; Authorize Supplemental Dental Benefit for the OneCare Connect Program, as well as Funding and Contracting with a Vendor as Necessary to Implement

Contact

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

Recommended Actions

1. Authorize modifications to the Board approved OneCare Connect (Cal MediConnect) Program member enrollment process to allow for enrollment by Long Term Care (LTC) Facility, subject to approval by the Department of Health Care Services (DHCS); and
2. Authorize the Chief Executive Officer (CEO) to contract with dental benefits administrator to provide a supplemental benefit to the Medi-Cal dental benefit subject to approval by the DHCS and the Centers for Medicare & Medicaid Services (CMS), and upon the successful negotiation of contract terms with Liberty Dental from July 1, 2015 to December 31, 2015.

Background

In actions taken on January 3, 2013, February 7, 2013 and December 5, 2013, the Board authorized the CEO to develop a provider delivery system for implementation of the Duals Demonstration, a program for beneficiaries eligible for Medi-Cal and Medicare or "Duals", also known as Cal MediConnect Program and branded by CalOptima as OneCare Connect.

On December 5, 2013 the Board approved the Member enrollment process in order to ensure a seamless passive enrollment of OneCare Connect members who will be allowed the opportunity to make a voluntary choice to disenroll (opt-out). The enrollment process, previously approved, is based on the DHCS requirements to passively enroll eligible members on their birthday month. Approximately 3,900 members in Orange County are expected to be eligible for passive enrollment monthly.

The Cal MediConnect program launched state wide on April 1, 2014 and has been implemented in six counties. Passive enrollment start dates have been staggered throughout the state and the opt-out rates have varied by county with an overall statewide average of 49%. Concerned about the high opt-out rate, CalOptima staff has developed strategies to mitigate opt-out. The member strategies include increasing member outreach efforts and outreach to our community stakeholders informed as they are considered our member's "trusted advisors". Provider strategies, as approved by your Board, include increased provider participation through the implementation of the Community Network and increasing primary care and specialist reimbursement from 80% to 100% of Medicare fee-for-service. Based on the experience of the other Cal MediConnect plans, staff proposes two additional strategies related to the member enrollment process and dental services.

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Discussion

As CalOptima prepares to launch the Cal MediConnect or OneCare Connect program, CalOptima staff has explored strategies intended to reduce the pre-enrollment opt-out and strengthening retention of members who are passively enrolled in the program. The strategies CalOptima staff considered are both from the member and provider perspective so as to ensure that both stakeholder groups are motivated to remain in OneCare Connect.

Long Term Care Facility Based Enrollment. From the member impact perspective, CalOptima is proposing to modify the previously approved passive enrollment strategy for individuals who are residing in Long-Term Care (LTC) Facilities. Among the approximately 80,000 Dual eligible individuals in Orange County, approximately 3,500 reside in 56 LTC facilities. These 3,500 individuals are among the most vulnerable members, have complex health care needs, and would greatly benefit from increased integration and coordination of care, which will be available with OneCare Connect. For this reason, CalOptima staff is proposing that it would be a better approach to passively enroll these Duals by LTC facility rather than by birth month based on DHCS approval and on a mutually agreed upon schedule with DHCS. This would allow CalOptima to communicate one-on-one with members and their families regarding care options available to them through OneCare Connect. CalOptima staff would also be able to personally educate providers and coordinate member care. Providing the opportunity to work closely with the LTC facilities, to educate and answer questions and provide the additional care coordination component will help improve the OneCare Connect retention rate.

Dental Benefit. Another proposal to improve the retention rate is by providing supplemental dental services not covered by Medi-Cal to CalOptima OneCare Connect members. While OneCare Connect members are eligible for Denti-Cal, in certain situations, access remains an issue. Management believes that improving access to dental services facilitates a positive member experience, thereby motivating members to stay in OneCare Connect. The CalOptima OneCare program previously offered a supplemental dental benefit that was very popular in attracting Duals to enroll in OneCare. Based on member input, CalOptima staff views the availability of dental services as a key component of a successful OneCare Connect program. Subject to approval by both DHCS and the Centers for Medicare & Medicaid Services (CMS), CalOptima management proposes to utilize funding from the DHCS for the Medi-Cal component of the Cal MediConnect capitation payment to implement this option.

If approved, staff recommends contracting with Liberty Dental Plan to administer and coordinate the proposed supplemental dental benefits for OneCare Connect members on a per member per month (PMPM) payment basis. Liberty Dental has been the dental benefit administrator that administered the OneCare benefit on behalf of CalOptima. Management believes that Liberty Dental Plan is the only potential subcontractor qualified to provide the appropriate supplement to the Medi-Cal benefit. Liberty Dental Plan will ensure timely access to a comprehensive, contracted network of primary and specialty Denti-Cal providers. Unlike in Denti-Cal where certain members may face delays or difficulty in accessing care, the proposed benefit would allow OneCare Connect members to have an

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assigned primary care dentist through which to obtain dental services to guarantee a straightforward and seamless path to dental coverage. Through this arrangement, CalOptima intends to:

- Increase CMC members' awareness of the dental benefit through education and outreach;
- Improve utilization of preventive dental services;
- Improve coordination between dental and physical health care providers;
- Provide limited supplemental benefits not covered under Denti-Cal; and
- Improve access to dental providers.

Both the LTC member enrollment and dental strategies require Board and regulator approval. Staff will return to the Board for additional authority, as necessary, to implement these and potentially other retention strategies.

Fiscal Impact

The recommended action to execute a contract with Liberty Dental Plan to provide supplemental dental benefits will have a total fiscal impact between $1.7 million and $2.0 million at capitation rates from $7.00 per member per month (PMPM) to $8.00 PMPM for Fiscal Year 2015-16. Under this capitated arrangement, Liberty Dental Plan will assume full risk for dental services, and will coordinate dental benefits with Denti-Cal. As such, the capitation payment will cover supplemental dental benefits only, including enhanced access to their dental network, with no additional payments made to Liberty Dental Plan. Denti-Cal will remain the primary payor and provider of dental services to OneCare Connect members.

Rationale for Recommendation

CalOptima staff recommends these actions to strengthen the OneCare Connect program's ability to minimize pre enrollment opt-out, maximize post enrollment retention and strong provider participation in the OneCare Connect program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *3/27/2015*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
VIII. J. Authorize Actions Related to OneCare Connect Enrollment

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions
1. Authorize implementation of transition plan of OneCare members to OneCare Connect effective January 1, 2016;
2. Authorize a one-month deeming period effective no sooner than September 1, 2015 for OneCare Connect members who no longer meet Cal MediConnect eligibility requirements due to loss of Medi-Cal eligibility with CalOptima;
3. Authorize enhancement of the delivery model for OneCare Connect members who reside in a long-term care facility that is exclusive to CalOptima Direct, subject to approval by the Department of Health Care Services and the Centers for Medicare & Medicaid Services; and
4. Authorize updates to policies as necessary for implementation.

Background
On December 5, 2013, the CalOptima Board of Directors authorized execution of the Three-Way Agreement between the California Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS) and CalOptima for implementation of Cal MediConnect (CMC), branded CalOptima OneCare Connect Plan (Medicare-Medicaid Plan) (OCC) in Orange County. OCC is a managed care plan that combines Medicare and Medi-Cal, including long-term services and supports (such as In-Home Supportive Services, Multipurpose Senior Services Program, Community-Based Adult Services, and long-term care). Both the DHCS and CMS have continued to issue guidance regarding the implementation of CMC. Two topics of recent regulatory discussion include the enrollment of Medicare Dual-Eligible Special Needs Plans (D-SNPs) and a period of deemed continued eligibility for CMC. Additionally, CalOptima is involved in ongoing communications with CMS and DHCS regarding initiatives specific to members residing in long-term care facilities.

Enrollment into D-SNPs
DHCS issued guidance through an All Plan Letter *(APL) 14-014: Enrollment Requirements for Dual-Eligible Special Needs Plan in Alameda and Orange Counties,* which delineates D-SNP enrollment criteria once CMC is implemented in a county. Specific to CalOptima, the APL states that if a D-SNP is also a CMC plan, the following will apply: "No earlier than January 1, 2016, DHCS will crosswalk all Duals who are eligible for CMC into the corresponding CMC plan once CMC is implemented in Orange County. These Duals will not be permitted to re-enroll in the CMC D-SNP; and the CMC D-SNP may serve any existing or new beneficiaries who are not eligible for CMC (Excluded Beneficiaries) only."

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Based on this guidance, CalOptima is required to transition its OCC-eligible OneCare Members into OCC effective January 1, 2016. OneCare can no longer enroll Members eligible for CMC. However, OneCare can continue to enroll dual eligible Members not eligible for CMC into the OneCare plan. These include, for example, Members under 21 years of age, Members receiving services through Regional Center or Members participating in Section 1115(c) waiver programs, such as Assisted Living, In Home Operations, and Nursing Facility/Acute Hospital Waivers. During this transition to OCC, Members are subject to the same noticing requirements as apply to Members being passively enrolled into OCC, and CalOptima staff is in the process of obtain approval of modifications to the existing notice templates so that they can be used in conjunction with this transition.

Deeming Process for CMC

Current OCC policy provides that Members, who lose Medi-Cal eligibility, as determined by the State, are disenrolled from the plan. DHCS, in compliance with CMS policy, issued guidance on June 15, 2015 encouraging plans such as CalOptima to offer an optional one or two-month period of deemed continued eligibility in the Medicare-Medi-Cal Plan (MMP) due to loss of Medi-Cal eligibility. For OCC members who lose eligibility with the plan due to 1) loss of Medi-Cal eligibility or 2) change of circumstance impacting eligibility (such as a change in Medi-Cal eligibility aid code or a move out of the service area), DHCS will allow plans to choose to provide a one or two month period of deemed continued eligibility. Deeming guidance became effective July 1, 2015.

Long-Term Care

CalOptima has been responsible for the Medi-Cal long-term care benefit since January 1996. The Medi-Cal long-term care benefit includes room and board for Members who are no longer able to live safely at home or in the community, require round-the-clock custodial care prescribed by a physician, and meet DHCS level of care requirements. These members receive medical, social, and personal care services in a nursing facility. Only care in sub-acute, skilled nursing facilities and intermediate care facilities apply; assisted living and board and care facilities are not eligible.

Traditionally, for Dual eligible members, physician and hospital services are provided through the Medicare fee-for-service program, a Medicare Advantage Plan, or a Special-Needs Plan. CalOptima has managed and paid for long-term care services for these members directly and has not delegated this responsibility. Through OCC, Dual eligible members can now receive all of their services through one coordinated plan.

Since 2009, CalOptima Medi-Cal members in long-term care have received physician, hospital, and long-term care services through the CalOptima Direct network, which includes the CalOptima Community Network. OCC now affords CalOptima the opportunity to provide the full scope of services covered under both Medicare and Medi-Cal through the CalOptima Community Network.

Discussion

Enrollment into D-SNPs

As indicated, effective January 1, 2016, CalOptima is required to transition eligible OneCare Members into OCC. CalOptima intends to make the transition as seamless as possible for Members

and ensure that disruption is kept to a minimum. For this reason, staff intends to assign the Member to the same OneCare primary care provider (PCP) and health network, unless otherwise requested by Member. If the PCP participates in a different OCC health network at the time of transition, the Member will be assigned to the same PCP and the PCP's new health network. This is in alignment with the DHCS March 27, 2015 Dual Plan Letter (DPL) 15-003 requirements for continuity of care which states "if the MMP contracts with delegated entities, the MMP must assign the beneficiary to a delegated entity that has the beneficiary's preferred PCP in its network."

If the member's OneCare PCP does not participate in the same OCC health network but does participate in two or more OCC health networks or none, the Member will be assigned according to the OCC auto-assignment policy initially approved during the December 2013 Board meeting and amended in May 2015, unless otherwise requested by Member.

CalOptima will modify its OCC policies related to primary care selection, network assignment, and member notification to the extent necessary to reflect the above.

Deeming Process for CMC

DHCS issued guidance allowing CMC plans to offer up to two months of deeming eligibility due to loss of Medi-Cal eligibility. The deeming period would apply to OCC members who no longer qualify for OCC due to loss of Medi-Cal eligibility or change of circumstance impacting Medi-Cal eligibility. Plans already participating in CMC have reported that many members who have been involuntarily disenrolled from CMC due to loss of Medi-Cal eligibility regain their Medi-Cal eligibility within one to two months after disenrollment.

For example, a Member may lose Medi-Cal eligibility as a result of late submission of annual Medi-Cal redetermination documentation, delays in redetermination processing, a report of having an out of county residence, or other health coverage information. In many instances, the situation is quickly remediated either by submission of required redetermination documentation or correcting erroneous records, and Medi-Cal eligibility is reinstated. Without a deeming period, these members will be disenrolled from OCC and cannot be automatically enrolled back to the plan. Instead, these members would have to voluntarily re-enroll with OCC to continue coverage.

In order to mitigate breaks in coverage and maintain continuity of care for members, staff proposes to allow a one-month deeming period for OCC Members. A one month deeming period is recommended at this time to limit CalOptima's financial exposure. Based on the proposed action, during the deeming period, CalOptima would continue providing OCC benefits to the Member. CalOptima will continue to receive member premium payments from Medicare; however, Medi-Cal capitation payments will be suspended during this time. Medi-Cal capitation payments from DHCS will be retroactively paid for the deeming month if the member regains Medi-Cal eligibility. However, if the Member does not regain Medi-Cal eligibility during the deeming period, the member would be disenrolled from OCC at the end of the deeming period month, and CalOptima would not be reimbursed for Medi-Cal expenses incurred on behalf of this member during the one-month period.

All regulatory notice requirements to Members will be followed for this process. While DHCS permits plans to implement deeming effective July 1, 2015, due to the time required for regulatory

approval of member materials, CalOptima staff proposes to implement the one month deeming process no earlier than September 1, 2015. As proposed, deeming will continue through the duration of the CMC, currently authorized by the DHCS and CMS through December 31, 2017.

CalOptima will modify its OCC policies related to member enrollment and disenrollment, to the extent necessary to implement the above.

Long-Term Care

On April 2, 2015, the CalOptima Board of Directors authorized staff to modify the OCC enrollment process to allow for enrollment by long-term care facility. Regulatory approval was received in July 2015 and the enrollment of members by facility will begin in November 2015. In order to enhance the care for OCC members residing in a long-term care facility, staff proposes to implement a delivery model specific for these members. By enhancing the delivery model, staff expects to:

- Improve coordination of Medicare and Medi-Cal services, consistent with the goals of Cal MediConnect
- Improve member, family and facility satisfaction
- Promote member enrollment in OCC
- Utilize emergency department (ED) and inpatient resources appropriately with subsequent reduction in ED visits, hospital admissions, days and readmissions rates
- Adhere to regulatory requirements for OCC
- Improve communication and discuss expectations with member, facility, providers, and family
- Measure and report benefits of integrated care

A key component of this delivery model is to contract with providers who provide services in skilled nursing and long-term care facilities. These providers are referred to as skilled nursing facility (SNF) physicians. Because these members permanently reside in the facility, it is important for the members' care to be rendered by physicians who go directly to the facility to provide services on a regular and frequent basis in order to identify and treat acute or deteriorating conditions. These physicians will also be available around-the-clock to provide urgent care services at the facility in order to avoid unnecessary emergency department admissions. As such, new contracts requiring the SNF physician to provide around-the-clock care and minimum thresholds of visits in addition to traditional primary care services will be developed. These contracts will be offered exclusively through CalOptima Direct to individual providers and physician groups and may be based on fee-for-service or capitated with a risk sharing agreement.

The other key component of enhancing the deliver model is to designate the managed CalOptima Community Network, a part of CalOptima Direct, as the assigned network for OCC members residing in a long-term care facility, similar to CalOptima's current policy for Medi-Cal members. The CalOptima Community Network is designed to provide physician, hospital, and long-term care services to all Medi-Cal members residing in a long-term care facility. For Dual eligible members, while physician and hospital services are provided through the Medicare fee-for-service program, a Medicare Advantage Plan, or a Special-Needs Plan, CalOptima has always managed and paid for long-term care services for these members directly. Assigning OCC members to CalOptima

Community Network, therefore, promotes continuity with their CalOptima Medi-Cal network. Additionally, this allows a single entity to be responsible for the members entire covered services.

Subject to approval by both the DHCS and CMS, CalOptima will modify and/or develop OCC policies related to health network selection, primary care selection, auto-assignment, and services provided to a member residing in a long-term care facility to the extent necessary to reflect the above.

Fiscal Impact
The recommended actions are budget neutral. Transition of OneCare members into OneCare Connect, expenses due to deeming, and direct costs related to the reimbursement to long-term care facilities are accounted for in the FY16 budget.

Rationale for Recommendation
In order to comply with the DHCS guidelines for OCC enrollment and to maintain maximum membership and minimize disruption of member's health care services, CalOptima staff proposes to implement the above recommended actions.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/31/2015*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. B. Authorize Modifications to Member Assignment Process for the OneCare Connect Program; Authorize Supplemental Dental Benefit for the OneCare Connect Program, as well as Funding and Contracting with a Vendor as Necessary to Implement

Contact

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

Recommended Actions

1. Authorize modifications to the Board approved OneCare Connect (Cal MediConnect) Program member enrollment process to allow for enrollment by Long Term Care (LTC) Facility, subject to approval by the Department of Health Care Services (DHCS); and
2. Authorize the Chief Executive Officer (CEO) to contract with dental benefits administrator to provide a supplemental benefit to the Medi-Cal dental benefit subject to approval by the DHCS and the Centers for Medicare & Medicaid Services (CMS), and upon the successful negotiation of contract terms with Liberty Dental from July 1, 2015 to December 31, 2015.

Background

In actions taken on January 3, 2013, February 7, 2013 and December 5, 2013, the Board authorized the CEO to develop a provider delivery system for implementation of the Duals Demonstration, a program for beneficiaries eligible for Medi-Cal and Medicare or "Duals", also known as Cal MediConnect Program and branded by CalOptima as OneCare Connect.

On December 5, 2013 the Board approved the Member enrollment process in order to ensure a seamless passive enrollment of OneCare Connect members who will be allowed the opportunity to make a voluntary choice to disenroll (opt-out). The enrollment process, previously approved, is based on the DHCS requirements to passively enroll eligible members on their birthday month. Approximately 3,900 members in Orange County are expected to be eligible for passive enrollment monthly.

The Cal MediConnect program launched state wide on April 1, 2014 and has been implemented in six counties. Passive enrollment start dates have been staggered throughout the state and the opt-out rates have varied by county with an overall statewide average of 49%. Concerned about the high opt-out rate, CalOptima staff has developed strategies to mitigate opt-out. The member strategies include increasing member outreach efforts and outreach to our community stakeholders informed as they are considered our member's "trusted advisors". Provider strategies, as approved by your Board, include increased provider participation through the implementation of the Community Network and increasing primary care and specialist reimbursement from 80% to 100% of Medicare fee-for-service. Based on the experience of the other Cal MediConnect plans, staff proposes two additional strategies related to the member enrollment process and dental services.

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Discussion

As CalOptima prepares to launch the Cal MediConnect or OneCare Connect program, CalOptima staff has explored strategies intended to reduce the pre-enrollment opt-out and strengthening retention of members who are passively enrolled in the program. The strategies CalOptima staff considered are both from the member and provider perspective so as to ensure that both stakeholder groups are motivated to remain in OneCare Connect.

Long Term Care Facility Based Enrollment. From the member impact perspective, CalOptima is proposing to modify the previously approved passive enrollment strategy for individuals who are residing in Long-Term Care (LTC) Facilities. Among the approximately 80,000 Dual eligible individuals in Orange County, approximately 3,500 reside in 56 LTC facilities. These 3,500 individuals are among the most vulnerable members, have complex health care needs, and would greatly benefit from increased integration and coordination of care, which will be available with OneCare Connect. For this reason, CalOptima staff is proposing that it would be a better approach to passively enroll these Duals by LTC facility rather than by birth month based on DHCS approval and on a mutually agreed upon schedule with DHCS. This would allow CalOptima to communicate one-on-one with members and their families regarding care options available to them through OneCare Connect. CalOptima staff would also be able to personally educate providers and coordinate member care. Providing the opportunity to work closely with the LTC facilities, to educate and answer questions and provide the additional care coordination component will help improve the OneCare Connect retention rate.

Dental Benefit. Another proposal to improve the retention rate is by providing supplemental dental services not covered by Medi-Cal to CalOptima OneCare Connect members. While OneCare Connect members are eligible for Denti-Cal, in certain situations, access remains an issue. Management believes that improving access to dental services facilitates a positive member experience, thereby motivating members to stay in OneCare Connect. The CalOptima OneCare program previously offered a supplemental dental benefit that was very popular in attracting Duals to enroll in OneCare. Based on member input, CalOptima staff views the availability of dental services as a key component of a successful OneCare Connect program. Subject to approval by both DHCS and the Centers for Medicare & Medicaid Services (CMS), CalOptima management proposes to utilize funding from the DHCS for the Medi-Cal component of the Cal MediConnect capitation payment to implement this option.

If approved, staff recommends contracting with Liberty Dental Plan to administer and coordinate the proposed supplemental dental benefits for OneCare Connect members on a per member per month (PMPM) payment basis. Liberty Dental has been the dental benefit administrator that administered the OneCare benefit on behalf of CalOptima. Management believes that Liberty Dental Plan is the only potential subcontractor qualified to provide the appropriate supplement to the Medi-Cal benefit. Liberty Dental Plan will ensure timely access to a comprehensive, contracted network of primary and specialty Denti-Cal providers. Unlike in Denti-Cal where certain members may face delays or difficulty in accessing care, the proposed benefit would allow OneCare Connect members to have an

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assigned primary care dentist through which to obtain dental services to guarantee a straightforward and seamless path to dental coverage. Through this arrangement, CalOptima intends to:

- Increase CMC members' awareness of the dental benefit through education and outreach;
- Improve utilization of preventive dental services;
- Improve coordination between dental and physical health care providers;
- Provide limited supplemental benefits not covered under Denti-Cal; and
- Improve access to dental providers.

Both the LTC member enrollment and dental strategies require Board and regulator approval. Staff will return to the Board for additional authority, as necessary, to implement these and potentially other retention strategies.

Fiscal Impact

The recommended action to execute a contract with Liberty Dental Plan to provide supplemental dental benefits will have a total fiscal impact between $1.7 million and $2.0 million at capitation rates from $7.00 per member per month (PMPM) to $8.00 PMPM for Fiscal Year 2015-16. Under this capitated arrangement, Liberty Dental Plan will assume full risk for dental services, and will coordinate dental benefits with Denti-Cal. As such, the capitation payment will cover supplemental dental benefits only, including enhanced access to their dental network, with no additional payments made to Liberty Dental Plan. Denti-Cal will remain the primary payor and provider of dental services to OneCare Connect members.

Rationale for Recommendation

CalOptima staff recommends these actions to strengthen the OneCare Connect program's ability to minimize pre enrollment opt-out, maximize post enrollment retention and strong provider participation in the OneCare Connect program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *3/27/2015*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Contracting with or Amending Contracts with Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

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

Recommended Action

Subject to approval by the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) of Board-authorized waiver request, authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into contracts, or amend contracts with Community Based Physicians (CBPs), except those associated with St. Joseph Health System, to serve as primary care providers for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE), as part of implementation of said waiver.

Rev. 12/7/2017

Background/Discussion

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. The CalOptima PACE Center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location.

In many cases, potential PACE-eligible participants wish to keep their existing primary care physician due to geographic considerations, as well as cultural and linguistic competencies. Allowing CalOptima PACE to contract with community-based physicians will allow CalOptima to enroll PACE participants who wish to access the PACE model of care, while maintaining their existing relationship with their primary care physician – often in their neighborhood and language.

On September 7, 2017, the CalOptima Board of Directors authorized staff to submit a waiver request to the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) to allow CBPs to serve as primary care providers to participants in the PACE program. The waiver has been submitted and CalOptima is waiting for a response.

If the waiver is approved, staff will contract with, or amend existing contracts with qualified primary care providers, in accordance with current contracting and rate strategies used for other CalOptima contracted Medicare primary care physicians. PACE participants will be able to access care from contracted CBPs where a PACE physician would typically be needed. If the waiver is approved, it is intended that CalOptima would implement the waiver as approved.

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Fiscal Impact

The Fiscal Year 2017-18 CalOptima Operating Budget, approved by the Board on June 1, 2017, includes projected expenses of $730,000 for PACE primary care physician services. The recommended action to enter into or amend contracts with CBPs to serve as primary care providers for PACE participants is budget neutral. The average cost per visit for CBP services are projected to be less than the costs for current center-based physician services.

Rationale for Recommendation

Implementation of the requested waiver, if approved, would provide greater flexibility for CalOptima's PACE center to contract with community-based primary care physicians, increasing access to participants to receive care in their neighborhood and their language, while also potentially eliminating a barrier to enrollment in PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Board Action dated September 7, 2017, Consider Authorizing Request for Waiver Allowing Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

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

11/30/2017 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

13. Consider Authorizing Request for Waiver Allowing Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

Richard Helmer, Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer to file a waiver request for CalOptima's Program of All-Inclusive Care for the Elderly (PACE) for Section 903 of the Benefits Improvement and Protection Act (BIPA) of 2000, to the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) in order to allow Community Based Physicians (CBP) to serve as the primary care provider, in collaboration with the PACE interdisciplinary team; and
2. ~~Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into contracts with CBPs to provide such services, subject to the requested waiver first being granted.~~ *Continued to future Board meeting.*

Rev. 9/7/17

Background/Discussion

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. The CalOptima PACE Center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location.

In many cases, potential PACE-eligible participants wish to keep their existing primary care physician due to geographic considerations, as well as cultural and linguistic competencies. Notably, CalOptima PACE currently serves participants who speak 22 different languages, highlighting the diverse Orange County community. Participants may travel up to 15 miles or up to one hour in a vehicle to see their primary care physician. Allowing CalOptima PACE to contract with community-based physicians will allow CalOptima to enroll PACE participants who wish to access the PACE model of care, while maintaining their existing relationship with their primary care physician – in their neighborhood and language.

Section 903 of BIPA allows for specific modifications or waivers of certain regulatory provision to meet the needs of PACE organizations. As such, CalOptima PACE is requesting for a waiver of the regulatory sections listed below from Title 42: Public Health,§460 – PACE, in order to allow a CBP to serve as the primary care provider on the interdisciplinary team:

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- § 460.102(a) *Basic requirement.* A PACE organization must meet the following requirements: (1) Establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each participant.

- § 460.102(d)(3) The members of the interdisciplinary team must serve primarily PACE participants.

This waiver request is to allow CBPs to serve as a primary care provider, as set forth in the PACE regulation, by providing primary care services in their respective clinic settings while also serving non-PACE participants.

Filing of a 903 BIPA Waiver application will not add to PACE expenditures. In fact, it will likely remove a primary barrier to enrollment by allowing participant access to primary care outside of PACE center-based physicians, likely resulting in increased enrollment growth.

If the waiver is approved, then staff would seek to contract with appropriate qualified primary care providers, in accordance with the current contracting and rate strategies used for other CalOptima-contracted Medicare primary care physicians (e.g., CalOptima Care Network PCPs for OneCare/OneCare Connect).

Fiscal Impact
The Fiscal Year 2017-18 CalOptima Operating Budget, approved by the Board on June 1, 2017, included projected expenses of approximately $730,000 for PACE primary care physician services. The recommended action to file a waiver request to allow CBPs to serve as the primary care providers for PACE participants is budget neutral. Staff anticipates CBPs will provide services where a PACE physician would typically be needed, and that the average cost per visit for CBP services will be less than the current PACE Center-based physician services

Rationale for Recommendation
This waiver would provide greater flexibility for PACE centers to contract with community-based primary care physicians, increasing access to participants to receive care in their neighborhood and their language, while also potentially eliminating a barrier to enrollment in PACE.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing and Directing Execution of Amendments to the Agreement with the California Department of Health Care Services (DHCS) for the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

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

Recommended Actions

1. Authorize and direct the Chairman of the Board of Directors to execute Amendment A04 to the PACE Agreement between DHCS and CalOptima ("DHCS PACE Agreement") regarding:
    a. Extension of the contract termination date to December 31, 2018
    b. Incorporation of revised language reflecting the Americans with Disabilities Act (ADA) for section 508 compliance, previously approved at the August 3, 2017 Board meeting; and
2. Authorize and direct the Chairman of the Board to execute a Future Rate Amendment to the DHCS PACE Agreement related to revised capitation rates for Calendar Year (CY) 2017.

Background

Since October 2009, the CalOptima Board has taken numerous actions related to the CalOptima PACE program. On June 6, 2013, the Board authorized the execution of the DHCS PACE Agreement as well as the agreement with the Centers for Medicare & Medicaid Services (CMS) for the operation of the CalOptima PACE site. Beginning in September 2015 and thereafter, the Board has authorized execution of various amendments to the DHCS PACE Agreement for Calendar Year (CY) payment rates and other provisions, as summarized in the Appendix to this agenda item.

The CalOptima DHCS PACE Agreement specifies, among other terms and conditions, the capitation payment rates CalOptima receives from DHCS to provide health care services. The current Agreement expires on December 31, 2017, while the capitation rates are meant to be renewed on a calendar year basis.

Discussion

On November 14, 2017, DHCS provided CalOptima with Amendment A04 for the DHCS PACE Agreement to include updates for:

- Extending the contract termination date to December 31, 2018.
- Formally incorporating the revised language reflecting the Americans with Disabilities Act (ADA) for section 508 compliance. This provision was previously presented and approved at the August 3, 2017 Board meeting. However, DHCS decided to move this into Amendment A04 instead of revising the already counter-signed Amendment 03.

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Rate Revisions – *Calendar Year 2017 Future Rate Amendment*

On August 29, 2017, DHCS provided CalOptima the *draft* proposed rates for CY 2017, for the period of January 1, 2017 through December 31, 2017 and the methodology used to develop them. The methodology is based on 95% of the "Amount That Would Have Otherwise Been Paid (AWOP)". DHCS is finalizing the CY 2017 rates and plans to submit them in November 2017 to CMS for review and approval. Upon CMS approval, DHCS will provide PACE plans with a rate amendment to incorporate all program changes retroactive to the beginning of calendar year 2017 and CalOptima staff anticipates that the CY 2017 amendment will be consistent with the draft materials provided to-date. If they are materially different than anticipated, CalOptima staff will return to the Board with further recommendations.

Rate changes for the period January 1, 2017 through December 31, 2017 reflect the following:

1. Revised capitation rates, *retroactive to January 1, 2017.*
    a. The Managed Care Organization (MCO) tax applies to capitation for the January 1, 2017 through June 30, 2017 period.

2. The revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population have built-in adjustments for Medi-Cal program changes:
    a. AB 97 (2011) Provider Payment Reductions.
    b. LTC County-Specific increases to account for the average LTC unit costs increase to include provider payments increase on AB1629 (2004) facilities and payment increases on other LTC facilities.
    c. IHSS unit cost increases: Welfare & Institutions Code section 12300.4 identifies two additional costs to the IHSS program: paying overtime and travel time for IHSS providers. Increases in the Personal Care category of service costs by 5.1% to account for the IHSS overtime and travel time program change effective February 1, 2016; 7.0% reduction effective for the period January 2015 through June 2015 applied on Personal Care utilization for all PACE Counties. 12.2% increase (Non-Dual) or 11.0% (Full-Dual) applied to Personal Care category of services to account for the hourly rate increase for independent IHSS providers.
    d. Mental Health: Increases to account for Mental Health benefit enhancements effective January 1, 2014.
    e. Restoration of Acupuncture services in 2017: County specific adjustment increase applied to Other Medical category of service for HCBS population.
    f. Dental rate revision to account for dental benefit for the NF population and the adult dental partial benefit restoration for the Medi-Cal Community-Based Long-Term Care population.
    g. Non-medical transportation (NMT) is non-emergent transportation to medical services for beneficiaries where the mode of transportation has no medical component. Effective July 1, 2017, NMT become a benefit for transportation to Medi-Cal services. A $0.05 PMPM adjustment for the Non-Medical Transportation benefit enhancement is included as a below-the-line add on to both Non-Dual and Full-Dual AWOP.

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3. All other terms and conditions in the CalOptima DHCS PACE Agreement remain unchanged.

Fiscal Impact

The recommended action to execute Amendment A04 to the DHCS PACE Agreement will allow for the implementation of final CY 2017 Medi-Cal PACE rates. Upon analysis, staff estimates the retroactive application of the revised capitation rates and actual PACE enrollment for the period of January 1, 2017, through December 31, 2017, results in a net increase of approximately $381,000, as compared to the originally accrued rates. This represents a 2.8% rate increase for the dual eligible population and a 3.0% increase for the Medi-Cal only population from previously accrued amounts.

Rationale for Recommendation

CalOptima's execution of Amendment A04 and Future Rate Amendment to the DHCS PACE Agreement is necessary to ensure compliance with the requirements and for the continued operation of CalOptima's PACE. CalOptima's FY 2017-18 Operating Budget incorporated the draft CY 2017 rates for PACE based on the CY 2016 capitation. Execution of a revised Amendment A04 and Future Rate Amendment will ensure that revenues and cash payments are consistent with the approved budget.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Appendix summary of amendments to PACE Primary Agreements
2. Board Action dated August 3, 2017, Consider Authorizing and Directing the Chairman of the Board of Directors to Execute a Revised Amendment A03 or a new Amendment A04 to the Agreement with the California Department of Health Care Services (DHCS) for the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

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

11/30/2017 — **Date**

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APPENDIX TO AGENDA ITEM 10.

The following is a summary of amendments to the PACE Primary Agreement approved by the CalOptima Board of Directors (Board) to date:

Amendments to Primary Agreement with DHCS	Board Approval
A01 provided revised Upper Payment Limit (UPL) and capitation rates for Calendar Year (CY) 2013 for the period of October 1, 2013 through December 31, 2013; and UPL methodology and CY 2014 rates for the period of January 1, 2014 through December 31, 2014. Revised capitation rates for the Medi-Cal *Dual* population and *Medi-Cal only* population to have built-in adjustments for Medi-Cal program changes. Also incorporated adult expansion group into aid code table: a. Added adult expansion aid codes M1, L1, 7U under adult expansion group. b. Added aid codes 3D and M3 under Family group.	September 3, 2015
A02 provided revised UPL and capitation rates for CY 2015 for the period of January 1, 2015 through December 31, 2015. Revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population to have built-in adjustments for Medi-Cal program changes.	September 3, 2015
A03 provided revised UPL and capitation rates for CY 2016 for the period of January 1, 2016 through December 31, 2016, and applied the Managed Care Organization (MCO) Tax for the period July 1, 2016 through December 31, 2016. Beginning on January 1, 2017 and onward, the rates revert back to the non-MCO tax period rates in effect from January 1, 2016 through June 30, 2016, until the 2017 rates are developed and implemented with a future amendment to the CalOptima DHCS PACE Agreement. Incorporates a revised HIPAA Business Associate Addendum, Exhibit H, to replace the former Exhibit G, as of the Amendment effective date, which will require compliance with DHCS' revised data security standards.	May 4, 2017
Amend* contract to include revised language reflecting the Americans with Disabilities Act (ADA) for 508 compliance. *On 9/20/17, DHCS informed CalOptima this would be moved to be captured in A04.	August 3, 2017
A04 provided an extension of the contract termination date to December 31, 2018 and incorporated ADA compliance language.	Pending

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Future Amendment (A05) provided draft capitation rates for CY 2017 for the period of January 1, 2017 through December 31, 2017, developed by the "Amount That Would Have Otherwise Been Paid (AWOP)", and apply the Managed Care Organization (MCO) Tax for the period January 1, 2017 through June 30, 2017.	Pending
Amendments to Primary Agreement with CMS	**Board Approval**
A01 CalOptima PACE initiated a waiver to allow Nurse Practitioners to provide primary care at PACE, which was approved by CMS on March 30, 2017 and added *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	December 1, 2016

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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

6. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute a Revised Amendment A03 or a new Amendment A04 to the Agreement with the California Department of Health Care Services (DHCS) for the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

Richard Helmer, Chief Medical Officer, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize and direct the Chairman of the Board of Directors (Board) to execute a revised Amendment A03 or a new Amendment A04 to the PACE Agreement between DHCS and CalOptima ("DHCS Agreement"); and
2. Until such Amendment is provided, authorize and direct the Chairman of the Board to provide assurances to the DHCS, with the assistance of legal counsel, of CalOptima's intent to comply with all applicable requirements.

Background

Since October 2009, the CalOptima Board of Directors has taken numerous actions related to the CalOptima PACE program. On June 6, 2013, the Board authorized the execution of the DHCS Agreement as well as the agreement with the Centers for Medicare & Medicaid Services (CMS) for the operation of the CalOptima PACE site. On September 3, 2015, the Board authorized execution of amendments A01 and A02 to the DHCS Agreement for the Calendar Year (CY) 2014 and CY 2015 rates, respectively. On December 1, 2016, the Board authorized CalOptima PACE to pursue a waiver to allow nurse practitioners to provide primary care at PACE, which was approved on March 30, 2017 and incorporated as an amendment to CalOptima's CMS PACE agreement.

On March 29, 2017, DHCS provided CalOptima with Amendment A03 for the DHCS Agreement that includes revised Upper Payment Limit (UPL) and capitation rates for calendar year 2016, and incorporates a revised HIPAA Business Associate Addendum, Exhibit H, which requires compliance with DHCS's revised data security standards. On May 4, 2017, the Board authorized execution of Amendment A03 to the CalOptima-DHCS Agreement for the CY 2016 rates and an updated Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum.

The CalOptima DHCS PACE Agreement specifies, among other terms and conditions, the capitation payment rates CalOptima receives from DHCS to provide health care services. The current Agreement expires on December 31, 2017, while the capitation rates are meant to be renewed on a calendar year basis.

Discussion

On June 6, 2017, DHCS's Contracts Management Unit (CMU) informed CalOptima of a requirement for all DHCS contracts to contain revised language reflecting the Americans with Disabilities Act

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(ADA). Inclusion of the updated ADA provision requires a revised Amendment A03 or new Amendment A04 t. The new language reads as follows:

Provision 6, "Americans with Disabilities Act" of *Exhibit A: Scope of Work* is added to read:

> 6. Americans with Disabilities Act
>
> Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement shall comply with the accessibility requirements of Section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973 as amended (29 U.S.C. § 794 (d), and regulations implementing that act as set forth in Part 1194 of Title 36 of the Federal Code of Regulations. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code section 11135 codifies section 508 of the Act requiring accessibility of electronic and information technology.

CalOptima staff does not foresee any challenges in ensuring compliance with the accessibility provision included in the ADA language as there are already existing processes in place for materials and electronic information, such as for the website, to be compliant with section 508 of the Rehabilitation Act of 1973, as amended (29 USC section 794(d).

All other terms and conditions in the CalOptima DHCS PACE Agreement remain unchanged.

Fiscal Impact
There is no anticipated fiscal impact for the recommended action to ratify Amendment A03 to include the updated ADA provision.

Rationale for Recommendation
CalOptima's execution of a revised Amendment A03 or new Amendment A04 to its Primary Agreement with DHCS is necessary to ensure compliance with the requirements and for the continued operation of CalOptima's PACE. CalOptima's FY 2017-18 Operating Budget incorporated the draft CY 2017 rates for PACE based on the CY 2016 capitation. Execution of a revised Amendment A03 or new Amendment A04 will ensure that revenues and cash payments are consistent with the approved budget.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to PACE Primary Agreements

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 6.

The following is a summary of amendments to the PACE Primary Agreement approved by the CalOptima Board of Directors (Board) to date:

Amendments to Primary Agreement with DHCS	Board Approval
A01 provided revised Upper Payment Limit (UPL) and capitation rates for Calendar Year (CY) 2013 for the period of October 1, 2013 through December 31, 2013; and UPL methodology and CY 2014 rates for the period of January 1, 2014 through December 31, 2014. Revised capitation rates for the Medi-Cal *Dual* population and *Medi-Cal only* population to have built-in adjustments for Medi-Cal program changes. Also incorporated adult expansion group into aid code table: a. Added adult expansion aid codes M1, L1, 7U under adult expansion group. b. Added aid codes 3D and M3 under Family group.	September 3, 2015
A02 provided revised UPL and capitation rates for CY 2015 for the period of January 1, 2015 through December 31, 2015. Revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population to have built-in adjustments for Medi-Cal program changes.	September 3, 2015
A03 provided revised UPL and capitation rates for CY 2016 for the period of January 1, 2016 through December 31, 2016, and applied the Managed Care Organization (MCO) Tax for the period July 1, 2016 through December 31, 2016. Beginning on January 1, 2017 and onward, the rates revert back to the non-MCO tax period rates in effect from January 1, 2016 through June 30, 2016, until the 2017 rates are developed and implemented with a future amendment to the CalOptima DHCS PACE Agreement. Incorporates a revised HIPAA Business Associate Addendum, Exhibit H, to replace the former Exhibit G, as of the Amendment effective date, which will require compliance with DHCS' revised data security standards.	May 4, 2017
Amend contract to include revised language reflecting the Americans with Disabilities Act (ADA) for 508 compliance.	Pending
Amendments to Primary Agreement with CMS	**Board Approval**
A01 CalOptima PACE initiated a waiver to allow Nurse Practitioners to provide primary care at PACE, which was approved by CMS on March 30, 2017 and added *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	December 1, 2016

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreement for the Medi-Cal Program with the California Department of Health Care Services (DHCS)

Contact

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

Recommended Actions

1. Authorize and direct the Chairman of the Board of Directors to execute an Amendment to the Primary Agreement for the Medi-Cal program between DHCS and CalOptima (DHCS Medi-Cal Contract) related:
    a. To rate changes; and
    b. To incorporate language related to the Medicaid Mental Health Parity Rule, Transportation, and American Indian Health Services.

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 which has been amended numerous times. Amendments to the DHCS Medi-Cal Contract are summarized in the attached appendix, including Amendment 31, which extends the DHCS Medi-Cal Contract through December 31, 2020. The DHCS Medi-Cal Contract contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services to Medi-Cal beneficiaries.

Discussion

Rate Changes

DHCS has informed CalOptima that it submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) on August 31, 2017 for approval that will revise rates for Classic Medi-Cal, Affordable Care Act (ACA) Optional Expansion (OE), Behavioral Health Treatment (BHT) and Hepatitis-C supplemental payments, and Partial Dual/Medi-Cal only rates for the period of July 2015 to June 2016.

DHCS' proposed amendment seeks to incorporate revised rates related to the base Medi-Cal Classic and ACA OE rates for the period July 2015 to June 2016, with BHT and Hepatitis-C supplemental payments, and Partial Dual/Medi-Cal only rates.

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The revised capitation base rates for July 2015 - June 2016 were sent to CalOptima in September 2017. The revised rates for the period reflect the following:

- Impact of California Senate Bill (SB) 239 (Hospital Quality Assurance Fee (HQAF)) and California Assembly Bill (AB) 85 adjustments at the lower and upper bound;
- Final rate ranges with and without SB 78 which are inclusive of HQAF and AB 85, and displays the percentage blend of age-adjusted Adult and Seniors and Persons with Disabilities (SPD) rates used for rate development;
- Adjustments applied to Medi-Cal Classic midpoint rates to create base data for OE;
- Rate range development for plan-specific ACA OE rate ranges; and
- Hepatitis C supplemental payment rates effective July 2015 through June 2016. These rates include amounts for both 340B and non-340B pricing.

BHT revised supplemental payment rates for the period of July 1, 2015 through June 30, 2016 were sent to CalOptima in September 2017. These final BHT rates contain the following updates:

- Rate ranges with and without SB 78; and
- Rate development process from base data through to the final county-specific BHT rate ranges.

The revised Coordinated Care Initiative Non-Duals rates (or "Partial Dual/Medi-Cal only rates") for the period of July 1, 2015 through June 30, 2016 were sent to CalOptima in September 2017. The revised rates for the period reflect the following:

- Lower and upper bound rates with SB 239 adjustments by category of aid for Managed Long-Term Support Services (MLTSS) non-dual and partial-dual population;
- Capitation rate calculation sheets by category of aid for the MLTSS non-dual and partial-dual population; and
- Rate summaries by category of aid and in total, for the MLTSS non-dual and partial-dual population.

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 herein, or if it includes significant unexpected language changes, Staff will return to the Board of Directors with further recommendations.

<u>Amendment for Medicaid Mental Health Parity, Transportation, and American Indian Health Services</u>

On October 2, 2017, DHCS submitted an amendment to CMS for approval that will incorporate language regarding the Medicaid Mental Health Parity, transportation benefits, and American Indian Health Services into managed care plan (MCP) contracts, including CalOptima.

Medicaid Mental Health Parity
On March 30, 2016, CMS issued the Medicaid Mental Health Parity Final Rule (CMS–2333F), which applies certain requirements from the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 to coverage offered by Managed Care Organizations (MCOs). General

parity requirements include financial requirements and quantitative treatment limitations on mental health (MH) and substance use disorder (SUD) benefits, which cannot be more restrictive or be applied more stringently than medical/surgical (M/S) benefits. Non-quantitative treatment limitations on MH or SUD benefits in processes, strategies, evidentiary standards, or other factors must be comparable to, and applied no more stringently than, limitations applied to M/S benefits, in the same classification. Parity requirements apply to all Medi-Cal managed care plans (MCPs), including CalOptima.

The amendment's language is consistent with the requirements in DHCS sub-regulatory guidance in All Plan Letters (APLs) 17-016: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care and 17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services. The amendment is intended to bring CalOptima's Primary Agreement with DHCS into compliance with mental health parity requirements on October 1, 2017, as required by Title 42, Code of Federal Regulations (CFR), Section 438.930.

Transportation
DHCS' proposed amendment also seeks to incorporate requirements related to transportation. The addition of this contract language is consistent with current APL guidance and SB 2394. Effective July 1, 2017, CalOptima began providing Non-Medical Transportation (NMT) for all CalOptima Medi-Cal members, subject to utilization controls and permissible time and distance standards, in order to obtain Medi-Cal covered services provided by CalOptima. Effective October 1, 2017, in part to comply with CMS–2333–F and to have a uniform delivery system, DHCS required that CalOptima begin providing NMT for all Medi-Cal services not covered under CalOptima's Primary Agreement with DHCS. These services include a range of carved-out services such as specialty mental health, substance use disorder, dental, and other benefits delivered through the Medi-Cal Fee-for-Service (FFS) program. CalOptima must also continue to cover emergency medical transportation and non-emergency medical transportation (NEMT), as well as referring and coordinating NEMT for carved-out services not covered under CalOptima's Medi-Cal contract with the DHCS. The amendment's language is consistent with the requirements in DHCS sub-regulatory guidance in APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services.

American Indian Health Services
Lastly, DHCS' proposed amendment seeks to incorporate payment requirements related to the American Indian Health Services Program. For services provided on or after January 1, 2018, MCPs, including CalOptima, shall reimburse American Indian Health Service programs at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service. However, MCPs shall also be entitled to receive a supplemental American Indian Health Service Program payment for qualified members who utilize services at American Indian Health Service Programs as reported by CalOptima. There are currently no Indian Health Service facilities operating in Orange County.

DHCS submitted the contract amendment to CMS for approval on October 2, 2017. 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 with further recommendations.

DHCS has further advised that once the contract amendment is finalized and sent to CalOptima for execution, it may require CalOptima to submit 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 deliverables that would ordinarily come to the Board for approval, including the revision or creation of certain P&Ps, staff will return to the Board for further consideration and/or ratification of staff action that was necessary to meet DHCS requirements.

Fiscal Impact

The final capitation rates for the period of July 2015 through June 2016 for Classic Medi-Cal and ACA OE rates under SB 239 result in an average per member per month increase of $36.53. By statute, CalOptima will pass through to eligible hospitals the full amount of supplemental HQAF funds it receives from DHCS.

Updates to the intergovernmental transfer (IGT) rate range for the period of July 2015 through June 2016 are budget neutral to CalOptima. Expenditures of IGT funds are for restricted, one-time purposes for providing enhanced benefits to existing CalOptima Medi-Cal members, and do not commit CalOptima to future budget allocations.

The revised capitation rates for Classic Medi-Cal, ACA OE, Hepatitis C, BHT, and Partial Dual/Medi-Cal only for the period of July 2015 through June 2016 under SB 78 are revenue neutral to CalOptima. By statute, CalOptima will return the full amount of MCO tax funds that it receives to DHCS.

Rationale for Recommendation

CalOptima's 2014-15 Operating Budget was based on the anticipated rates for FY 2015-16. The addition of language regarding the Medicaid Mental Health Parity Rule, transportation benefits, and American Indian Health Services to the DHCS Medi-Cal Contract is necessary to ensure compliance with the requirements of CMS 2333–F, SB 2394, and DHCS APLs 17-016 and 17-018.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Primary Agreement approved by the CalOptima Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

The following is a summary of amendments to the Secondary Agreement approved by the CalOptima Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014

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A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Authorizing and Directing Execution of the Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute a new three-way Agreement between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program that removes language pertaining to In-Home Supportive Services (IHSS) and incorporates other regulatory updates. This new three-way Agreement replaces the prior version in its entirety.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. On September 7, 2017, the Board authorized execution of a new Agreement, to replace the prior Agreement in its entirety and served to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

On November 14, 2017, CMS contacted the California Association of Health Plans (CAHP) to request they share with all MMPs in California that CMS would be issuing a new three-way Agreement for review and one-week comment period from the MMPs. The draft version of the amendment for comment was issued on November 21, 2017, with top priority areas of MMP comments/questions due to CMS/DHCS by December 4, 2017. This timeline was developed to ensure that CMS receives signed copies of the agreements by Christmas with an effective date of January 1, 2018.

As noted in the September 7, 2017 staff report (attached), this second phase update of the three-way agreement includes changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

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Discussion

Upon receipt of the redline version of the new three-way Agreement on November 21, 2017, CalOptima staff reviewed changes in the requirements and determined there were no significant concerns to comment on for submission to CMS/DHCS.

After the final version of the new three-way Agreement is received on or around December 20, 2017, CalOptima staff will also evaluate the document to determine whether any subsequent policy and procedure (P&P) changes are needed to align with requirements in the new three-way Agreement. If the final version Agreement is not consistent with staff's understanding as presented herein or if it includes material unexpected changes, staff will return to the Board for further consideration. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action on these P&Ps.

Following is a summary of key changes contained in the new three-way Agreement:

Section	Summary of Change in Requirement
Definitions	New terms added and several existing definitions were revised.
Compliance	2.1.3 Despite the County-Organized Health System (COHS) plans' exemption from Knox-Keene licensure for their Medi-Cal business, this Contract obligates all Contractors(MMPs), including COHS plans, to comply with all provisions of this Contract, including the contractual provisions relating to the Knox-Keene Act, unless otherwise expressly excluded. 2.1.6 In the event an All Plan Letter(APL) applies to an MMP, DHCS and CMS will jointly issue a memo to the plans via HPMS for the interim period between an APL issuance and a Duals Plan Letter (DPL) issuance. *CMS noted the added APL language for this provision is still under review with DHCS leadership.*
Enrollment Activities	New verbiage for Streamlined Enrollment, which is not applicable in COHS counties.
Disenrollments	2.3.2.3 Enrollees with a share of cost that do not meet the share of cost on the first of the month will be deemed eligible and remain enrolled for up to two (2) months before being disenrolled
Covered Services – Care Plan Options (CPO)	2.4.3.1 The grievance and appeals process for CPO services shall be the same process as used for others benefits authorized by the MMP

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Section	Summary of Change in Requirement
Care Delivery Model	2.5.1 While still required to abide by the care delivery model described within the Three-Way Contract, MMP is not required to submit a "model of care" to CMS or DHCS, unless otherwise requested. 2.5.2.6 / 2.5.2.16 / 2.6.2 / 2.10.7 *and throughout* - Removal of coverage of IHSS, while still maintaining a requirement to coordinate with county agencies for IHSS services. IHSS is no longer a Covered Service under this Contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (Senate Bill (S.B). 97). 2.5.2.7 Ensuring an adequate ratio of Care Coordinators to Enrollees to provide Care Coordination as required through this Contract. The CMT shall monitor the ratio of Care Coordinators to Enrollees on a regular basis. 2.5.2.8 through 2.5.2.11 Requirements on next steps for MMP to follow when a Member refuses participation in the ICT and ICP. 2.5.2.12 Requirement for transferring encounter, assessment, ICP and other pertinent information to assure Continuity of Care of a Member when they opt out or transfer to another MMP.
Health Risk Assessment, ICP, and Care Coordination	2.8.3 Requirement for MMP to provide the ICP to the Enrollee no less than semi-annually.
Continuity of Care	2.8.4.1.9 New provision on Out of Network Reimbursement Rules.
Indian Health Network	2.10.14.3 For services provided on or after January 1, 2018, MMP shall reimburse Indian Health Care Providers who provide Covered Services to Indian Enrollees, who are eligible to receive services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and MMP shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Care Provider.

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Section	Summary of Change in Requirement
Authorization of Services	2.11.5.5.4 Requirement to include name and telephone number of the health care professional responsible for the denial, delay, or modification. 2.11.5.6.1 For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires, within five (5) working days from receipt of the information reasonably necessary to render a decision, and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days.
Risk Sharing Settlement	4.3.3.1.2 Removed provisions related to Interim Settlement process
Payment Terms	4.3.5.1 Requirement clarified to include retroactive adjustments, as applicable. 4.3.5.1.2.1 Clarified provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).
Modification to Capitation Rates	4.3.6.5 Clarified provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this contract for service dates on or after January 1, 2018.
Reconciliation	4.6.2.1 Clarified provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this contract for service dates on or after January 1, 2018. 4.6.3.1 New provision to outline Final Medicare Reconciliation Settlement, in the event MMP terminates or non-renews contract.
Appendix A: Covered Services	A.2.1.3.1 Explicitly states December 31, 2017 end date for coverage of IHSS services as a covered benefit. A.3.2 Requirement for MMP to provide unlimited Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) for medically necessary services. Removed the former 30 one-way trip limitation for NMT.

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Section	Summary of Change in Requirement
Appendix J: Eligible Populations	Simplified the provision for eligibility determination for IHSS recipients with a Share of Cost (SOC), to remove passive enrollment stipulations for IHSS recipients to meet SOC in the fifth and fourth months prior to their effective date.

Fiscal Impact

The recommended action to execute the new three-way Agreement, for the removal of language pertaining to IHSS is projected to decrease both OneCare Connect revenue and expenses by $31.4 million for the January to June 2018 period. The decrease in funding and claims expense was anticipated and included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. Management plans to account for the removal of IHSS related revenue and expenses for the period of July 1, 2018, through December 31, 2019, in future operating budgets.

The recommended action to incorporate other regulatory updates is expected to be budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new three-way Agreement with DHCS and CMS is necessary to ensure compliance with the requirements and for the continued operation of CalOptima's Cal MediConnect (OneCare Connect) program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Appendix summary of amendments to the Agreement with DHCS and CMS for Cal MediConnect
2. Board Action dated September 7, 2017, Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services, and the Centers for Medicare & Medicaid Services for the Cal MediConnect Program

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 12

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015
New Three-way Agreement (Agreement), to replace prior agreement in its entirety Extends the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).	September 7, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS), and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

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policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

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Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

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Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Appointment to the CalOptima Board of Directors' Provider Advisory Committee

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

Recommended Action
The Provider Advisory Committee (PAC) recommends:
1. Appointment of the following agency-selected voting liaison representative to the PAC effective upon Board approval:
    a. Mary R. Hale, Behavioral Health Director, Orange County Health Care Agency Representative.

Background
Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of advisory committees. The CalOptima Board of Directors established the Provider Advisory Committee by resolution on February 14, 1995 to provide input to the Board. The PAC is comprised of fifteen voting members. Pursuant to Resolution No. 15-0806-03, PAC members serve three-year terms with the exception of the one standing seat, which is represented by the Orange County Health Care Agency. The CalOptima Board of Directors is responsible for the appointment of all PAC members.

Discussion
Pursuant to Resolution No. 15-0806-03, upon notice of the retirement of PAC Member Alan Edwards, M.D., Orange County Health Care Agency representative, CalOptima staff contacted the Orange County Health Care Agency and requested they recommend a representative to serve as a voting member on the PAC. Upon consideration of the candidate at the November 9, 2017 PAC meeting, the PAC is unanimously recommending this appointment and is forwarding the following candidate to the Board of Directors for consideration.

The recommended voting candidate is:

Orange County Health Care Agency
Mary R. Hale*

Mary Hale is the Behavioral Health Director for the Orange County Healthcare Agency where she has the responsibility for client centered/directed care and recovery of clients, families and communities' quality, through a comprehensive community system of care for behavioral health. Ms. Hale serves on a number of statewide committees and associations, many of which focus on co-occurring mental health and substance use disorders.

*Recommended Candidate

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Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The Orange County Health Care Agency representative on the PAC is a standing seat and not subject to the recommended three (3) year term. The nominee has been appointed to the PAC seat by the Orange County Health Care Agency as per policy and recommended by the PAC at their November 9, 2017 meeting.

Concurrence
Provider Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/30/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Adoption of Resolution Approving Revised CalOptima 2018 Compliance Plan and Authorizing the Chief Executive Officer (CEO) to Approve Revised and Retired Office of Compliance Policies and Procedures

Contact

Silver Ho, Compliance Officer, (714) 246-8400

Recommended Actions

1. Adopt Resolution No. 17-1207, Approving Revised CalOptima 2018 Compliance Plan; and
2. Authorize the CEO to Approve Revised and Retired Office of Compliance Policies and Procedures.

Background

CalOptima is committed to conducting its operations in compliance with ethical standards and all applicable laws, regulations, and rules, including those pertaining to its Federal and State health care program operations. As part of that commitment, on December 1, 2016, the CalOptima Board of Directors reviewed and approved the updated Compliance Plan, which includes the Code of Conduct, and the Fraud, Waste, and Abuse (FWA) Plan. The Compliance Plan comprehensively addresses the fundamental elements necessary for an effective compliance program including those elements identified by the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) and the Centers for Medicare & Medicaid Services (CMS).

Discussion

CalOptima regularly reviews the Compliance Plan to ensure it is up-to-date and aligned with Federal and State health care program requirements and laws and as well as CalOptima operations. CalOptima's Executive Director of Compliance (Compliance Officer) has reviewed the Compliance Plan and compliance Policies and Procedures to ensure consistency with applicable Federal and State health care program laws, regulations, and/or guidance.

Compliance Program Elements

Federal laws and regulations (including the federal U.S. Sentencing Guidelines, CMS Medicare Advantage regulations) and the OIG compliance guidance require that Compliance Programs be reasonably designed, implemented, and enforced, in order to ensure the Compliance Program is effective in preventing and detecting violations of standards or law. CalOptima's Compliance Program addresses each of the seven (7) fundamental elements of an effective Compliance Program, in addition to FWA detection, prevention, and remediation.

Written Standards

As part of the Compliance Program, CalOptima develops, maintains, and distributes to its Board Members, Employees, and First Tier, Downstream or Related Entities (FDRs) written standards in

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the form of the Compliance Plan, a Code of Conduct, and written Policies and Procedures, as further detailed in the Compliance Plan. The Compliance Plan incorporates all of the elements of an effective Compliance Program as recommended by the OIG and required by CMS regulations. The Compliance Plan incorporates a comprehensive FWA Detection and Prevention section, which establishes guidelines and procedures designed to detect, prevent, and remediate FWA in CalOptima Programs.

Oversight
The CalOptima Board of Directors (the "Board"), the governing body of CalOptima, is responsible for ensuring and overseeing the implementation, effectiveness, and continued operation of the Compliance Program. The Board delegates to the CEO, who then delegates to the Compliance Officer, a CalOptima Employee, the administration of the Compliance Program's development, maintenance, implementation, monitoring, and enforcement activities. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in the Compliance Plan. The Audit & Oversight Committee (AOC), a subcommittee of the Compliance Committee, chaired by the Director of Audit & Oversight, is responsible for overseeing the internal business and delegated activities.

Training and Education
Utilizing web-based training courses, as well as distribution of guidelines and publications, the Compliance Program incorporates training and educational courses governing CalOptima's compliance standards and requirements, as well as specialized educational courses assigned to individuals based on their respective roles, or positions, within, or with, CalOptima's departments and its programs. CalOptima Board Members, Employees, and FDRs receive copies of CalOptima's Code of Conduct and are required to complete comprehensive training covering compliance obligations and applicable laws, FWA (where applicable), and Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements, upon appointment, hire, or commencement of a contract, as applicable, and annually thereafter.

Lines of Communication and Reporting
CalOptima utilizes various methods to communicate general information, regulatory updates, and process changes from the Compliance Officer to CalOptima Board Members, Employees, FDRs, and members, including, but not limited to, presentations at meetings and updates in print and/or electronic form, including information on how to identify, report, and prevent compliance issues and FWA. CalOptima Board Members, Employees, FDRs, and/or Members receive information and reminders to report compliance concerns, questionable conduct or practices, and suspected, or actual, non-compliance issues, or FWA incidents, through one (1) of CalOptima's multiple reporting mechanisms. These reporting options, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). CalOptima maintains and supports a no retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or FWA.

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Enforcement and Disciplinary Standards
Board Members, Employees, and FDRs are subject to appropriate disciplinary and/or corrective actions for non-compliance with CalOptima's standards, requirements, or applicable laws as specified in the Compliance Program documents and related Policies and Procedures, including, but not limited to, CalOptima's policies on Progressive Discipline, Corrective Action Plans and/or Sanctions. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance, or unethical behavior, is determined, and appropriate disciplinary action is implemented to address improper conduct, activity, and/or behavior.

Monitoring, Auditing, and Identification of Risks
CalOptima has implemented and continues to implement comprehensive monitoring and auditing activities related to its operations and those of its FDRs. The purpose of CalOptima's monitoring and auditing activities is to test and confirm compliance with all applicable regulations, contractual agreements, and Federal and State laws, as well as applicable Policies and Procedures established to protect against non-compliance and potential FWA in CalOptima Programs. The Compliance Plan and related Policies and Procedures, address the monitoring and auditing processes that are carried out by CalOptima.

Response and Remediation
Once a violation, or an offense, has been detected or reported, CalOptima initiates all necessary steps to investigate, identify, and respond appropriately to the violation, or offense, and to prevent similar violations and offenses from occurring. As described in the Compliance Plan, CalOptima will conduct a timely and documented investigation, and undertake appropriate corrective actions where appropriate, including, but not limited to, modifying its Compliance Program and its Policies and Procedures to prevent the same, or similar, violation or offense, from occurring in the future.

Summary of Changes
The Compliance Plan has been updated and revised as follows:

- Amended the monitoring and auditing activities to describe and delineate CalOptima's readiness assessment process, and other monitoring and auditing activities, for new delegates;
- Modified the responsibilities of the AOC;
- Updated the CalOptima departments responsible for exclusion monitoring;
- Clarified the roles and responsibilities of the Compliance Committee;
- Clarified the oversight responsibilities of the CalOptima Board of Directors;
- Added mailing information for reporting compliance issues to the Office of Compliance;
- Added language regarding how CalOptima communicates its non-retaliation policy;
- Added a provision regarding obligations related to overpayments;
- Revised the compliance reporting, review, and recordkeeping schedules to ensure consistency with the Medicaid Managed Care Final Rule; and
- Revised the defined terms.

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Policies and Procedures
To align with the revised Compliance Plan, and consistent with applicable Federal and State health care program laws, regulations and/or guidance, the Compliance Officer, with the support of the Office of Compliance staff, updated related Policies and Procedures. The summary of changes is included in Attachment 3.

Fiscal Impact
There is no anticipated fiscal impact based on the adoption of the updates to the 2018 Compliance Plan and its related Policies and Procedures. To the extent that there is any fiscal impact due to increases in Compliance Program resources, such impact will be addressed in separate Board actions or the CalOptima Fiscal Year 2018-19 Operating Budget.

Rationale for Recommendation
To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima staff recommends that the Board approve and adopt CalOptima's updated 2018 Compliance Plan, and related Policies and Procedures. The updated 2018 Compliance Plan will supersede the prior updated Compliance Plan and FWA Plan approved on December 1, 2016. No changes have been made to the Code of Conduct, last updated and approved by the Board on October 3, 2013. Staff also recommends that the Board authorize the CEO to approve revised and retired related Policies and Procedures to implement the updated 2018 Compliance Plan.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 17-1207, Resolution Approving CalOptima's Updated 2018 Compliance Plan and Authorize the Chief Executive Officer (CEO) to Approve Revised and Retired Policies and Procedures
2. Draft 2018 Compliance Plan (redlined and clean versions).
3. Summary of Proposed Actions to CalOptima Office of Compliance Policies and Procedures.
4. Revised Office of Compliance Policies and Procedures (redlined and clean versions).

/s/ Michael Schrader — *11/30/2017*
Authorized Signature — **Date**

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RESOLUTION NUMBER 17-1207

RESOLUTION OF THE BOARD OF DIRECTORS OF ORANGE COUNTY HEALTH AUTHORITY dba CalOptima

APPROVING CALOPTIMA'S UPDATED 2018 COMPLIANCE PLAN

WHEREAS, Section 4.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provides that the Board of Directors is the governing body of CalOptima, and except as otherwise provided by the Bylaws or by Ordinance, the powers of CalOptima shall be exercised, its property controlled and its business and affairs conducted by or under the direction of the Board; and

WHEREAS, the Board of Directors has responsibility for approving, implementing, and monitoring a Compliance Program governing CalOptima's operations consistent will all applicable laws, regulations, and guidelines; and

WHEREAS, the Board of Directors supports CalOptima's commitment to compliant, lawful and ethical conduct and values the importance of compliance and ethics in Caloptima's operations; and

WHEREAS, the Board of Directors last reviewed and approved the Compliance Program on December 1, 2016 including the Compliance Plan, Code of Conduct, and Fraud, Waste, and Abuse Plan; and

WHEREAS, the Board of Directors reviews the Compliance Program documents on a periodic basis to ensure the Compliance Program is consistent with and updated to reflect applicable laws, regulations, and guidelines and to demonstrate the Board of Director's commitment to an effective Compliance Program.

NOW THEREFORE, BE IT RESOLVED:

Section 1. The Board of Directors hereby approves the 2018 Compliance Plan.

Section 2. The Board of Directors hereby approves and adopts the revised and retired Office of Compliance Policies and Procedures.

Section 3. The Chief Executive Officer or his/her designee is hereby authorized and directed to implement, monitor, and enforce the Compliance Program.

Section 4. These actions are effective upon the date of adoption of this Resolution.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, dba CalOptima, this 7th day of December 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

Orange County Health Authority

dba CalOptima

~~2017~~ 2018 Compliance Plan

(Revised December 2017)~~(Revised December 2016)~~

Document maintained by:
Silver Ho
CalOptima Compliance Officer

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations and rules, including those pertaining to Medi-Cal, Medicare, PACE (Program of All-Inclusive Care for the Elderly), MSSP (Multipurpose Senior Services Program), and other CalOptima programs.

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and monitoring responsibilities related to CalOptima's First Tier, Downstream, and Related Entities (FDRs), such as health networks, physician groups, participating providers, suppliers, pharmacy benefit manager (PBM), and consultants. The term FDR is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS). Such persons/entities, referred to as FDR herein, include those that directly contract with CalOptima and those that are Downstream or Related Entities (i.e. subcontracts) with CalOptima's First Tier Entities.

CalOptima has developed a comprehensive Compliance Program applicable to all of CalOptima's Programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "OneCare"), its Medicare-Medicaid Plan (MMP referred to as "OneCare Connect"), PACE, and MSSP. The Compliance Program incorporates all of the elements of an effective Cc~~c~~ompliance Pp~~p~~rogram as recommended by the Office of the Inspector General (OIG) and required by CMS regulations. The Compliance Program is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that CalOptima Board Members, Employees, and FDRs conduct themselves in accordance with the requirements of CalOptima's Compliance Program.

B. THE COMPLIANCE PLAN

This Compliance Plan sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently monitor adherence to all applicable laws, regulations, and guidelines. The Compliance Plan addresses the fundamental elements of an effective Compliance Program and identifies how CalOptima is implementing each of the fundamental elements of an effective Compliance Program in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the Compliance Plan is designed to provide guidance and to ensure that CalOptima's operations and the practices of its Board Members, Employees, and FDRs comply with contractual requirements, ethical standards, and applicable law.

This Compliance Plan is adopted by the Governing Body. It was developed and is managed by the Executive Director of Compliance (referred to hereinafter as the "Compliance Officer") with the Compliance Committee. Because the complex laws governing CalOptima and its programs are constantly evolving, the Compliance Plan may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board Members, Employees, and FDRs are expected to review and adhere to the requirements and standards set forth in the Compliance Plan, the Code of Conduct, and all related Policies and Procedures, as may be amended. Furthermore, Board Members, Employees, and FDRs are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a Board Member, Employee, and/or FDR has/have any questions about the application, or implementation, of this Compliance Plan, or questions related to the Code of Conduct or CalOptima Policies and Procedures, he or she should seek guidance from the Compliance Officer and/or the CalOptima Office of Compliance.

I. WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable fFederal and sState standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of Board Members, Employees, and FDRs, CalOptima develops, maintains, and distributes its written standards in the form of this Compliance Plan, a separate Code of Conduct, and written Policies and Procedures.

a. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to CalOptima Board Members, Employees, and FDRs. This Compliance Plan also includes a comprehensive section articulating CalOptima's commitment to preventing Fraud, Waste & Abuse (FWA), and setting forth guidelines and procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Programs. The Compliance Plan is available on CalOptima's external wWebsite for Board Members and FDRs as well as on CalOptima's internal intranet site, referred to as InfoNet, accessible to all Employees.

b. Policies and Procedures

CalOptima also developed written Policies and Procedures to address specific areas of CalOptima's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima can efficiently monitor adherence to all applicable laws, regulations, and guidelines. These policies are designed to provide guidance to Board Members, Employees, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, Employees, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Compliance Officer, or Ddesignee, will ensure that Board Members, Employees, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained in accordance with applicable record retention standards.

The Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's Policies and Procedures are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, meets regularly to review and approve proposed changes and additions to CalOptima's Policies and Procedures. Policies and Procedures are available on CalOptima's internal website and Compliance 360, a separate web portal accessible to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum.

c. Code of Conduct

Finally, the Code of Conduct is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the Code of Conduct is to articulate compliance expectations and broad principles that guide CalOptima Board Members, Employees, and FDRs in conducting their business activities in a professional, ethical, and lawful manner. The Code of Conduct is a separate document from the Compliance Plan and can be found in Appendix A ~~of the Compliance Plan~~. The Code of Conduct is approved by CalOptima's Board of Directors and distributed to Board Members, Employees, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II. OVERSIGHT

The successful implementation of the Compliance Program requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by CalOptima's Board, the Compliance Officer, the Compliance Committee, the Audit & Oversight Committee, and s~~S~~enior m~~M~~anagement.

a. Governing Body

The CalOptima Board of Directors, as the Governing Body, is responsible for approving, implementing, and monitoring a Compliance Program governing CalOptima's operations. The CalOptima Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Compliance Officer. The Compliance Officer is an employee of CalOptima, who handles compliance oversight and activities full-time. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the CalOptima Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima and monitoring the status of the Compliance Program to ensure its efficient and successful implementation.

To ensure the CalOptima Board exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's Compliance Program, the CalOptima Board:

- Understands the content and operation of CalOptima's Compliance Program;
- Approves the Compliance Program, including this Compliance Plan and the Code of Conduct;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the Compliance Program outcomes, including, but not limited to, results of internal and external audits;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the Compliance Program;

- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, Corrective Action Plans, Warning Letters, and/or ~~more formal Sanctions~~sanctions;
- Receives regularly scheduled, periodic updates from CalOptima's Compliance Officer and Compliance Committee, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the Compliance Program.

The CalOptima Board reviews the measurable indicators of an effective Compliance Program and remains appropriately engaged in overseeing its efficient and successful implementation; however, the CalOptima Board delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The Executive Director of Compliance serves as the Compliance Officer ~~and~~ who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and monitors the day-to-day activities of the Compliance Program. The Compliance Officer reports directly to the CEO and the Compliance Committee on the activities and status of the Compliance Program. The Compliance Officer has authority to report matters directly to the CalOptima Board at any time. Furthermore, the Compliance Officer ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The Compliance Officer interacts with the CalOptima Board, CEO, CalOptima's executive and departmental management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, FDR and internal oversight, Policies and Procedures, and training on compliance activities.

The CalOptima Board delegates the following responsibilities to the Compliance Officer, and/or ~~his or her~~his/her ~~designee~~Designee(s):

- ~~Chair~~ the Compliance Committee, which shall meet no less than quarterly and ~~which committee~~ assists the Compliance Officer in fulfilling ~~his or her~~his/her responsibilities;
-
- ~~Ensure~~ that the Compliance Program, including this Compliance Plan and Policies and Procedures, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected Board Members, Employees, and FDRs, as appropriate;

- Oversee and monitor the implementation of the Compliance Program, and provide regular reports no less than quarterly to the CalOptima Board and CEO summarizing all efforts, including, but not limited to, the Compliance Committee's efforts to ensure adherence to the Compliance Program, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and audit activities;

- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential FWA received from any source through any reporting method;

- Design, coordinate, and/or conduct regular internal audits to ensure the Compliance Program is ~~being~~ properly implemented and followed, in addition ~~and~~ to ~~ensure~~ verifying all appropriate financial and administrative controls are in place;

- Develop and implement an annual schedule of Compliance Program activities for each of CalOptima's Programs, and regularly report CalOptima's progress in implementing those plans to the appropriate Board Committee and/or to the Board of Directors;

- Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or FWA issues, including facilitating any documentation or procedural requests by such agency/ies;

- Oversee and monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., DHCS and CMS) and consult with legal counsel, as necessary;

- Create and coordinate educational training programs and initiatives to ensure that the CalOptima Board, Employees, and FDRs are knowledgeable about CalOptima's Compliance Program, including the Code of Conduct, Policies and Procedures, and all current and emerging applicable statutory and regulatory requirements;

- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate Corrective Action Plans, Sanctions, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and

- Coordinate with CalOptima departments and FDRs to ensure exclusion screening (including through the OIG List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), and Medi-Cal Suspended &

Ineligible (S&I) Provider List ~~Manual)~~ has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

~~►~~

c. Compliance Committee

The Compliance Committee, chaired by the Compliance Officer, is composed of CalOptima's senior management and operational staff, as designated by the CEO. The members of the Compliance Committee serve at the discretion of the CEO and may be removed, or added, at any time. The role of the Compliance Committee is to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the Compliance Program.

The CalOptima Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the CalOptima Board;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges);
- Review and Monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective~~Review and monitor the effectiveness of the Compliance Program, including monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing corrective actions to ensure they are promptly and effectively implemented~~;
- Analyze applicable federal and state program requirements~~s~~, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the Compliance Officer to ensure the adequacy of the Compliance Program~~Develop standards of business conduct and Policies and Procedures to promote compliance~~;
- Review, approve, and/or update Policies and Procedures to ensure the successful implementation and effectiveness of the Compliance Program consistent with regulatory, legal, and contractual requirements;
- Recommend and monitor the development of internal systems and controls to implement CalOptima's standards and Policies and Procedures as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Compliance Officer accordingly;
- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports of Monitoring and Auditing of areas in which CalOptima is at risk of program non-compliance and/or potential FWA, and ensure CAPs and ICAPs are implemented and Monitored for effectiveness~~Review and address reports designating areas in~~

~~which CalOptima is at risk for program non-compliance and potential FWA, and ensure that Corrective Action Plans are implemented and monitored for effectiveness~~;

- ~~►~~ Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its FDRs conduct activities and operations in compliance with the applicable law and regulations and sound business ethics; and
- ~~►~~
- ► Provide regular and ad-hoc status reports of compliance with recommendations to the CalOptima Board of Directors~~Provides regular and ad-hoc reports on the status of compliance with recommendations to the CalOptima Board~~.
- ~~►~~

d. Audit & Oversight Committee (AOC)

The Audit & Oversight Committee (AOC) is a subcommittee of the Compliance Committee and is chaired by the Director of Audit & Oversight. The AOC is responsible for overseeing the delegated and internal activities of CalOptima. The Compliance Committee has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in the AOC charter. In addition to the monthly scheduled meetings, the AOC may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the AOC presented are approved by a quorum. A quorum is defined as one (1) over fifty percent (50%). AOC may approve and/or implement Corrective Act Plans (CAPs); however, recommendations for FDR sanctioning and/or de-delegation are submitted to the Compliance Committee for final approval. The AOC also contributes to external reviews and accreditation audits, such as the National Committee for Quality Assurance (NCQA).

Responsibilities of the Audit & Oversight Committee with regard to FDRs include:

- ► Annual review, revision, and approval of the ~~Audit & Oversight Department Program Description , Policies and Procedures, and~~ audit tools;
- ► Review findings of the pre-delegation audit and readiness assessment to evaluate a potential FDR's ability to perform the delegated function(s);
- ► Review and approve potential FDR entities for delegation of functions;
- ► Ensure written agreements with each delegated FDR clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- ► Conduct formal, ongoing evaluation and monitoring of FDR performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite audit;
- ► Ensure all Downstream and Related Entities are monitored in accordance with CalOptima oversight procedures;
- ► Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis;
- ► Initiate and manage Corrective Action Plans (CAPs) for compliance issues;
- ► Propose Sanctions, subject to the Compliance Committee's approval, if an FDR's performance is substandard and/or violates the terms of the applicable agreement; and

- Review and initiate recommendations, such as termination of delegation, to the Compliance Committee for unresolved issues of compliance.

Responsibilities of the Audit & Oversight Committee with regard to internal business functions include:

- Annual review, revision, and approval of the Audit & Oversight Department Program Description and audit tools;
- Conduct formal, ongoing evaluation and monitoring of internal business areas' performance and compliance through review of periodic reports submitted, ongoing monitoring, and findings of the annual audit;
- ~~►~~ Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- ~~►~~
- Initiate and manage Corrective Action Plans (CAPs) for compliance issues.

e. Senior Management

The CEO and other executive management of CalOptima shall:

- Ensure that the Compliance Officer is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective C~~c~~ompliance P~~p~~rogram;
- Receive periodic reports from the Compliance Officer of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including audit findings, notices of non-compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III. TRAINING

Education and training are critical elements of the Compliance Program. CalOptima requires that all Board Members, Employees, ~~Temporary Employees,~~ and FDRs complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's Code of Conduct, compliance obligations, and relevant laws, and FWA, as applicable. Specialized education courses are assigned to individuals based on their respective roles~~,~~ or positions~~,~~ within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing seniors and people with disabilities (SPD) and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the Compliance Program, and which courses are updated regularly to ensure that employees are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The Compliance Officer is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The Compliance Officer and the CalOptima management staff are responsible for ensuring that Board Members, Employees, ~~Temporary Employees,~~ and FDRs complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's Code of Conduct to Board Members, Employees, and FDRs. Board Members, Employees, ~~Temporary Employees,~~ and FDRs are required to sign an attestation acknowledging receipt, review, and understanding of the Code of Conduct within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each person's files, as ~~legally~~ required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires Board Members, Employees, ~~Temporary Employees,~~ and FDRs, regardless of role~~,~~ or position~~,~~ with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the Compliance Program; FWA training; HIPAA privacy and security requirements; ethics; and a high level overview of the Medicare and Medi-Cal Programs. CalOptima's training courses cover CalOptima's commitment to compliance with f~~F~~ederal and s~~S~~tate laws and regulations, contractual obligations, internal policies, and ethics. Elements of the Compliance Program are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or FWA issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's HIPAA privacy and security training course covers the administrative, technical, and physical safeguards necessary to secure m~~M~~embers' protected health information(PHI) and personally identifiable information (PII).

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the Compliance Program requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each Employee. Board Members and FDRs are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some FDRs may be exempt or deemed to have met the FWA training and education requirement if the FDR has met the CMS requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically and records of completion are maintained for each individual as required by law.

c. Additional Training

The ~~Compliance Department~~Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the Compliance Program. These training opportunities are available to managers and Employees depending on their respective roles~~,~~ or positions~~,~~ within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing managers the tools and resources to train and share the information with Employees in their respective departments. If additional training related to FWA is required, the Compliance Officer will develop relevant materials.

Employees have access through CalOptima's internal intranet website (referred to as the "InfoNet") to CalOptima's Policies and Procedures governing the Compliance Program and pertinent to their respective roles and responsibilities. Employees may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board ~~members~~ Members receive a copy of the Compliance Plan, Code of Conduct, and Policies and Procedures pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the CalOptima Board. Board ~~members~~ Members may receive additional compliance training related to the CalOptima Board's role in overseeing and ensuring organizational compliance with CalOptima's Compliance Program.

The Code of Conduct and Policies and Procedures pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to FDRs upon commencement of the FDR contract. FDRs are required to disseminate copies of the Code of Conduct and Policies and Procedures to their employees, agents, and/or Downstream Entities. CalOptima may also develop compliance training and education presentations and/or roundtables for specified FDRs.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the Compliance Program and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to Policies and Procedures, contact information for the Compliance Officer, relevant federal and state fraud alerts and policy letters, pending/new legislation reports, and advisory bulletins from the Compliance Officer to CalOptima Board Members, Employees, ~~Temporary Employees,~~ FDRs, and members, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the CalOptima Board, FDRs, Employees, individual CalOptima departments, and members.

- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to Board Members, Employees, and FDRs, which contains CalOptima's updated Policies and Procedures.

- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to Board Members, Employees, FDRs, and ~~members~~Members.

- Electronic Mail – The CEO, ~~or~~ Compliance Officer, or their respective ~~designee~~Designee, periodically sends out email communications and/or alerts to Board Members, Employees, FDRs and/or ~~members~~Members, as applicable.

- CalOptima's Internal Intranet Website – CalOptima maintains an internal intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to Employees.

- CalOptima's Compliance Internal Website – The ~~Regulatory Affairs & Compliance Department~~Office of Compliance maintains an internal department website accessible to CalOptima Employees to communicate different Compliance initiatives, notices, key documents and forms, and updates to the Compliance Program, Code of Conduct, and/or Policies and Procedures.

- Postings – The ~~Regulatory Affairs & Compliance Department~~Office of Compliance posts ~~flyers concerning key initiatives, themes, and updates~~information on how to report potential issues of non-compliance and FWA throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima E~~e~~mployees.

- Written Reports – The Compliance Officer, in coordination with the CEO and Compliance Committee, prepares written monthly reports concerning the status of the Compliance Program to be presented to the CalOptima Board.

- Direct Contact with the Compliance Officer - Board Members, Employees, ~~Temporary Employees,~~ and FDRs can obtain additional compliance information directly from the Compliance Officer. Any questions, which cannot be answered by the Compliance Officer, shall be referred to the Compliance Committee.

b. Reporting Mechanisms

CalOptima Board Members, Employees, ~~Temporary Employees,~~ and FDRs have an affirmative duty and are directed in CalOptima's Code of Conduct and Policies and Procedures to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by Board Members, Employees, ~~Temporary Employees,~~ and/or FDRs to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an FDR contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or FWA incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and FWA issues are also provided to Board Members, Employees, FDRs, and M~~m~~embers in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or FWA.

Upon receipt of a report through one (1) of the ~~following~~ listed mechanisms, the Compliance Officer shall follow appropriate Policies and Procedures to promptly review, investigate, and resolve such matters. The Compliance Officer shall monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. Report Directly to a Supervisor~~,~~ or Manager

CalOptima employees are encouraged to contact their immediate S~~s~~upervisor, or M~~m~~anager, when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. The S~~s~~upervisor, or M~~m~~anager, will promptly escalate the report to the Compliance Officer for further investigation and reporting to the CalOptima Compliance Committee. If an Employee is concerned that ~~his or her~~his/her S~~s~~upervisor~~,~~ or M~~m~~anager~~,~~ did not adequately address ~~his or her~~his/her report~~,~~ or complaint, the Employee may go directly to the Compliance Officer, or the CEO.

2. Call the Compliance and Ethics Hotline

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with Spanish and English capability, in which CalOptima may receive anonymous issues on a confidential basis. Members are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or FWA issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all Board Members, Employees, FDRs, and M~~m~~embers. Members also have access to the Compliance Officer through the Compliance and Ethics Hotline~~hotline~~ and/or the right to contact the OIG Compliance Hotline directly.

3. Report Directly to the Compliance Officer

The Compliance Officer is available to receive reports of suspected or actual compliance violations, or FWA issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from Board Members, Employees, FDRs and m~~M~~embers. The Compliance Officer may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. FDRs are generally contractually obligated to report suspected Fraud and Abuse to CalOptima pursuant to regulatory and contractual requirements.

4. Report Directly to Office of Compliance

Reports may be made directly to CalOptima's Office of Compliance via mail, ~~or~~ email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA 92868

~~.~~

5. Confidentiality and Non-Retaliation

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA,

issues in good faith. This non-retaliation policy extends to reports received from FDRs and Mmembers. CalOptima's non-retaliation policy is communicated along with reporting instructions by by posting information on the CalOptima InfoNet and website, as well as sending periodic member notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the Compliance Officer will review and enforce disciplinary and/or other Corrective Action Plans for violations, as appropriate, with the approval of the Compliance Committee.

V. ENFORCEMENT AND DISCIPLINARY STANDARDS

Board Members, Employees, and FDRs are provided copies of CalOptima's Code of Conduct and the Compliance Plan and have access on CalOptima's internal and external website to applicable Policies and Procedures, including, but not limited to, CalOptima's Progressive Discipline Policy and Office of Compliance Policies addressing Corrective Action Plans and Sanctions. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance~~,~~ or unethical behavior~~,~~ is ~~determined~~confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board Members, Employees, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures, including CalOptima's Progressive Discipline Policy, as applicable. Board ~~members~~Members, Employees, and FDRs may be disciplined~~,~~ or sanctioned, as applicable, for failing to adhere to CalOptima's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- ~~►~~ Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- ►
- ~~►~~ Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs;
- ►
- ► Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures and/or contracts; or
- ~~►~~ Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one (1) of the reporting mechanisms.
- ►
- ► Conduct that violates HIPAA and other privacy laws and/or CalOptima's HIPAA privacy and security policies, including actions that harm the privacy of m~~M~~embers, or the CalOptima information systems that store m~~M~~ember data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions. - Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties,

Sanctions, and/or termination, depending on the nature and severity of the conduct, or behavior. Board Members may be subject to removal, Employees are subject to discipline, up to and including termination, and FDRs may be sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative Ssanctions and/or penalties. Further, violations could lead to suspension, or exclusion, from participation in Federal and/or State Health Care Programs.

CalOptima Employees shall be evaluated annually based on their compliance with CalOptima's Compliance Program. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

VI. MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with monitoring and auditing are identified through a combination of activities: risk assessments, Audit & Oversight and Compliance Committee discussions and decisions, and internal and external reporting. Through monitoring, auditing, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The Compliance Officer will collaborate with the Compliance Committee to identify areas of focus for monitoring and auditing potential non-compliant activity and FWA issues. A Compliance Risk Assessment will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of FDRs. Operations and processes will be evaluated based on: (1) deficiencies found by regulatory agencies; (2) deficiencies found by internal and external audit and monitoring reports; (3) the institution of new or updated procedures; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by CMS and the OIG Work Plan shall be used as resources to evaluate operational risks.

The Compliance Officer will work with the Chief Operating Officer, or ~~his or her~~his/her ~~designee~~Designee, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring monitoring and auditing. Those operational areas determined to be high risk may be subject to more frequent monitoring and auditing, as well as additional reporting requirements. The risk assessment process will be managed by the Compliance Officer, or his/her ~~designee~~Designee, and presented to the Audit & Oversight Committee (AOC), and subsequently to the Compliance Committee, for review and approval. Monitoring plans will be developed in collaboration with the operational areas, and focused audits may be scheduled based on the results of the ongoing monitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine monitoring and auditing activities to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Policies and Procedures to protect against non-compliance and potential FWA in CalOptima Programs. Monitoring activities are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An audit is a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., ~~policies~~ Policies and ~~procedures~~Procedures, laws and regulations) used as base measures. As part of the monitoring process, CalOptima has created a dashboard, which is a monitoring tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with monitoring operations and outcomes and to identify areas in need of targeted auditing on at least a monthly basis. Information taken from the dashboard along with grievance and

complaint call information will be used to develop monitoring and auditing work plans. Monitoring and auditing work plans are used to detect potential areas of risk and/or non-compliant activity. The monitoring and auditing work plans are subject to daily updates and additions, and are therefore, working documents. The Compliance Officer, in collaboration with the AOC and Compliance Committee, develops the monitoring and auditing work plans to address the risks associated with each of CalOptima's Programs.

The Compliance Officer will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate auditing and monitoring activities. Audits for each operational area will be conducted throughout the year consistent with the monitoring and auditing work plans. The Compliance Officer will coordinate the audits with internal audit staff, and, in some cases, with the assistance from an outside vendor. Audit methodologies shall be consistent with regulatory requirements and standards. All audits will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the audit review is completed, the audit team will ~~meet with~~communicate the results to the Compliance Officer ~~to discuss results~~ and propose follow up corrective action(s), if necessary. The Compliance Officer will provide reports to the CEO and the Compliance Committee concerning the results of the audits. The AOC reports to the Compliance Officer and the Compliance Committee on audits that involve FDRs as discussed below. If Fraud, Waste, or Abuse (FWA) issues are identified during an audit, the matter will be further investigated and resolved in a timely manner. In addition, an audit of the Compliance Program and its effectiveness should occur at least annually, and the results shall be reported to the CalOptima Board.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to CMS, DHCS, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight monitoring and auditing process of FDRs who perform delegated activities. The processes that CalOptima implements to oversee, monitor, and audit FDRs are incorporated into CalOptima's written Policies and Procedures, including processes involving pre-contractual evaluations and audits of First Tier Entities. CalOptima may implement Corrective Action Plans, Sanctions, and/or revoke its delegation of duties (in a manner permitted under the contract) if CalOptima determines that an FDR is unable~~,~~ or unwilling~~,~~ to carry out its responsibilities consistent with statutory and contractual obligations.

The Compliance Officer, or his/her D~~d~~esignee, determines the process for monitoring delegated FDRs and develops the annual monitoring and audit calendar in order to validate compliance with contractual standards and regulatory requirements. The AOC is responsible for overseeing all of the delegated activities and will review the pre-delegation audit, ensure the annual review of FDRs for delegated functions are completed, conduct formal on-going evaluation of FDR performance and compliance, ensure Downstream and Related Entitles are monitored, and impose Corrective Action Plans and/or Sanctions if the FDR's performance fails to meet statutory and contractual standards and requirements. The AOC may recommend termination of delegation to the Compliance Committee for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. Initial Evaluation

Prior to executing a contract or delegation agreement with a potential FDR, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's Policies and Procedures, is completed to determine the ability of the potential FDR to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, CMS, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not excluded in the OIG List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Award Management (SAM), or the DHCS Medi-Cal Provider Manual from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the Audit & Oversight Committee and subsequently the Compliance Committee for review and/or approval.

2. Contracting with FDRs

Once an entity has been approved, the delegation agreement specifies the activities CalOptima delegates to the FDRs, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and audits, and remedies, including disciplinary actions, available to CalOptima. Prior to any sub-delegation to any Downstream or Related Entity, a First Tier Entity must obtain approval from CalOptima. CalOptima determines who will directly monitor the Downstream or Related Entity's compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the FDR and their contractually delegated area(s). Furthermore, FDRs will be required to complete, sign, and return attestation forms confirming the FDR's compliance with new hire and annual training and education requirements, which includes courses on general compliance and FWA as well as exclusion screening and FWA reporting obligations.

3. Annual Risk Assessment

The Compliance Officer, or ~~his or her~~his/her D~~d~~esignee, will conduct an annual comprehensive risk assessment to determine the FDR's vulnerabilities and high risk areas. High risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed high risk, or vulnerable, is presented to the AOC for suggested follow-up audit. FDRs determined to be high risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Compliance Officer, or his/her D~~d~~esignee, and presented to the AOC and subsequently to the Compliance Committee for review and approval.

4. FDR Performance Reviews and Audits

CalOptima conducts a periodic comprehensive performance review of the FDR's ability to provide delegated services in accordance with contractual standards and applicable state, CMS, and accreditation requirements, as further detailed in CalOptima's Policies and Procedures. CalOptima may conduct audits of FDRs at any time. Such audits may include an evaluation of the FDR's training and education program and materials covering general compliance and FWA, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High risk FDRs, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual audit calendar; however, CalOptima does not limit its auditing schedule to only high risk FDRs.

If CalOptima has reason to believe the FDR's ability to perform a delegated function is compromised, an additional focused audit may be performed. The Compliance Officer may also recommend focused audits upon evaluation of non-compliant trends or reported incidents. The results of these audits will be reported to the AOC and then to the Compliance Committee.

A focused audit may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- Failure to comply with regulatory requirements and/or the CalOptima's service level performance indicators;
- Failure to comply with a Corrective Action Plan;
- Reported or alleged Fraud, Waste, and/or Abuse;
- Significant policy variations that deviate from the CalOptima or state, CMS, or accreditation requirements;
- Bankruptcy, or impending bankruptcy, which may impact services to members (either suspected or reported);
- Sale, merger, or acquisition involving the FDR;
- Significant changes in the management of the FDR; and/or
- Changes in resources which impact CalOptima's and/or the FDR's operations.

5. Corrective Actions and Additional Monitoring and Auditing

The Compliance Officer shall submit regular reports of all monitoring, audit, and corrective action activities to the Compliance Committee. In instances where non-compliance is identified, a Corrective Action Plan shall be developed by the FDR and reviewed and approved by the Compliance Officer, or ~~his or her~~his/her D~~d~~esignee. Every Corrective Action Plan is presented to the AOC for review. Supplemental and focused audits of FDRs, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement Sanctions~~,~~ or require remediation by an FDR~~,~~ for failure to fulfill contractual obligations including development and implementation of a Corrective Action Plan. Failure to cooperate with CalOptima in any manner may result in termination of the delegation agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's auditing process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the auditing processes, including Policies and Procedures, audit tools, and audit findings, to ensure all regulatory requirements are being audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- The central database of all pending, active, and terminated FDRs to monitor and track functions, performance, and audit schedules;
- Implementation of an escalation process for compliance/performance issues;
- Implementation of a process for validation of audit tools;
- Implementation of a process for noticing FDRs and functional areas of Corrective Action Plans;
- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding delegation standards, auditing, and monitoring FDR performance; and/or
- Implementation a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of FDR performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight audits completed within twelve (12) months; and
- Corrective Action Plans (CAPs) completed within the established timeframe.

f. Regular Exclusion Screening

As detailed in CalOptima's Policies and Procedures, CalOptima performs Participation Status Reviews by reviewing the OIG –LEIE, the GSA–SAM, and DHCS Medi-Cal Suspended & Ineligible Provider Lists ~~Provider Manual lists~~ upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, Employees, and/or FDRs are not excluded, or do not become excluded from participating in Federal and/or State health care programs~~federal and state health programs~~. Board Members, Employees, and FDRs are required to disclose their Participation Status as part of their initial appointment, employment, commencement of the contract and registration/application processes and when Board Members, Employees, and FDRs receive notice of a suspension, exclusion, or debarment during the period of appointment,

employment, or contract term. CalOptima also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

The Compliance Officer will review reports from Employees responsible for conducting the Participation Status Reviews to ensure Employees record and maintain the results of the reviews and notices/disclosures. Employees shall immediately notify the Compliance Officer of affirmative findings of a person, or entity's, failure to meet the Participation Status Review requirements. If CalOptima learns that any prospective, or current, Board Member, Employee, or FDR has been proposed for exclusion or excluded, CalOptima will promptly remove him/her/the FDR from CalOptima's Programs consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of their suspension, exclusion, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. The Compliance Officer will review potential organizational obligations related to the reporting of identified excluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII. RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's Compliance Program and/or FWA issues, the Compliance Officer shall, upon promptly verifying the facts related to the violation or likely violation, notify the Compliance Committee, as appropriate. The Compliance Committee (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, Sanctions, termination of any agreement and/or any other corrective action (including repayment of ~~overpayments~~Overpayments) consistent with applicable Policies and Procedures, subject to consultation with legal counsel and/or notifying the Governing Body, as appropriate;
- Implementing education and training programs for Board Members, Employees, and/or FDRs, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's Compliance Plan, Code of Conduct, and/or relevant Policies and Procedures in an effort to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding ~~Compliance~~ compliance matters are appropriately secured.

It is the responsibility of the Compliance Officer and the Compliance Committee to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable Policies and Procedures after considering such recommendations. The Compliance Officer, or ~~his or her~~his/her ~~designee~~Designee, shall monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning Ff~~f~~raud schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims activity indicates that Fraud may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a Fff~~f~~raud alert is received, CalOptima shall review its delegation agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the delegation agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a Ff~~f~~raud alert. With the issuance of a Ff~~f~~raud alert, CMS places CalOptima on notice (see Title 42, Code of Federal Regulations, ~~Section~~ §423.505(k)(3)) that claims involving the identified party needs to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged Ff~~f~~raud scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes member complaints, DHCS Audits and Investigations referrals, MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of Federal and/or State health care programs~~state or federal health care program~~ requirements. CalOptima shall also maintain files that contain documented warnings (e~~i~~.g~~e~~., Ff~~f~~raud alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, DHCS, CMS, and CMS' designee, regarding monitoring of FDRs within CalOptima's network that DHCS, or CMS, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent Fraud, Waste, and Abuse (FWA) within a CalOptima program. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of FWA activity. CalOptima shall assess all FDRs for potential Overpayments when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return Overpayments consistent with applicable law and regulatory guidance. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of Overpayment determinations to regulatory agencies, as required by law.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima's Compliance Program. FWA activities are implemented and overseen by CalOptima's Compliance Officer in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for FWA investigations. The Compliance Officer reports FWA activities to the CalOptima Compliance Committee, CEO, the CalOptima Board, and regulatory agencies.

CalOptima utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima promptly investigates suspected FWA issues and implements disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Programs is~~are~~ appropriately delivered to M~~m~~embers and resources are effectively utilized in accordance with f~~F~~ederal and s~~S~~tate guidelines. CalOptima incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

1. TRAINING

As detailed above, FWA training is provided to all Board Members and Employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA. FDRs are also required to complete FWA training, as described above. CalOptima's FWA training provides guidance to Board Members, Employees, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected~~,~~ or actual~~,~~ FWA;
- Examples of the most common types of member FWA (see Appendix B, attached hereto and incorporated herein) and FDR FWA (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima's PACE Program (e.g., suspicious activities suggesting PACE participants or their family members may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in the PACE program, etc.);
- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug

claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);

- How to report potential FWA using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for FDRs, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the False Claims Act and CalOptima's requirement to train Employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima shall provide Board Members, Employees, FDRs, and members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II. DETECTION OF FWA

a. Data Sources

In partnership with the Regulatory Affairs & Compliance Department, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of FWA. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. Members, FDRs, Employees, law enforcement and regulatory agencies, and others are able to contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect FWA include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline, or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Monitoring and auditing activities;

- Monitoring external health care FWA cases and determining if CalOptima's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and audits.

b. Data Analytics

CalOptima uses technology and data analysis to reduce FWA externally. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect FDRs based on billing patterns.

CalOptima also uses the services of an external Medicare Secondary Payer (MSP) vendor to reduce costs associated with its Medicare Advantage Part D program, OneCare, by ensuring that Medicare funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data is analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed in accordance with applicable state or federal law if they meet certain criterion that warrants additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (for example narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the PBM will conduct data mining activities in order to identify potential issues of FWA.

The following trends will be reviewed and flagged for potential FWA, including:

- Over utilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual Coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;

- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected FWA. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM will go through the same risk assessment process. The analysis will be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or makes arrangements to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides a number of refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA actually exists. The following list

below highlights common industry indicators and red flags that are used to determine whether or not to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the member/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA database and a report is generated and submitted to the Compliance Officer, Compliance Committee, and CEO.

III. INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (Access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU, or a designee, interviews the individual who reported the FWA, affected members and/or FDRs, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership, as necessary;
- Review of member enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;

- After an allegation is logged into the Fraud Tracking System, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking System shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation shall be forwarded to the Compliance Officer and Compliance Committee for discussion and approval.

IV. FINDINGS, RESPONSE, AND REMEDIATION

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, new policy implementation, and/or criminal or civil action. When the root cause of the potential FWA issue has been identified, the SIU will track and trend the FWA allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether or not disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima's Policies and Procedures, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima Policies and Procedures, CalOptima shall take appropriate disciplinary, or corrective, action against Board Members, Employees, and/or FDRs related to validated instances of FWA. CalOptima will also assess FDRs for potential Overpayments when reviewing and undertaking corrective actions. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, Corrective Action Plans, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the correction action may be applied universally.

V. REFERRAL TO ENFORCEMENT AGENCIES

CalOptima's SIU shall coordinate timely referrals of potential FWA to appropriate regulatory agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS and/or DHCS, as soon as possible after discovery, but no later than

ten (10) working days to DHCS after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to MEDIC after a OneCare, OneCare Connect, or PACE case is reported to CalOptima's SIU.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond the CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life, or well-being, of CalOptima members; and/or
- Schemes with large financial risk to CalOptima, or its members.

VI. ANNUAL EVALUATION

CalOptima's Compliance Committee shall periodically review and evaluate the FWA activities and its effectiveness as part of the overall Compliance Program monitoring and audit activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Compliance Plan, and other input from applicable sources.

VII. RETENTION OF RECORDS

CalOptima shall maintain reports and summaries of FWA activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of member records containing PHI in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of FWA investigations in a secure and confidential manner, regardless of the outcome of an investigation.

VIII. CONFIDENTIALITY

CalOptima and its FDRs shall maintain all information associated with suspected, or actual, FWA in confidential files, which may only be released in accordance with applicable laws and CalOptima Policies and Procedures. All participants and attendees of CalOptima's Quality Improvement Committee, Compliance Committee, and respective subcommittees, shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the Compliance Program, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the Compliance Program against the elements of an effective Cc~~c~~ompliance Pp~~p~~rogram as recommended by OIG and required by CMS regulations. The following areas will be reviewed:

- Policies and procedures;
- Compliance Officer and Compliance Committee;
- Training and education of Board Members, Employees, and FDRs;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal monitoring and auditing; and
- Prompt responses to detected offenses.

The Compliance Program will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with Ss~~s~~enior Mm~~m~~anagement, the Compliance Committee, and the CalOptima Board. Updates to the Compliance Program will be based on the results of the evaluation and will be referred to the CalOptima Board for review and approval.

E. FILING SYSTEMS

The Compliance Officer shall establish and maintain a filing system (or systems) for all compliance-related documents. The following files shall be established at CalOptima (as applicable):

Compliance Plan, Code of Conduct, and Policies and Procedures File

This file shall contain copies of the following (unless originals specified):

- Compliance Plan and any amendments;
- Any Compliance Program Policies and Procedures issued after the initiation of the Compliance Program;
- Reports to, and Resolutions/Minutes of CalOptima's Board approving the Compliance Program, Compliance Plan, Code of Conduct and/or appointment of the Compliance Officer;
- All non-privileged communications to the Compliance Officer (original);
- All Compliance Committee and CalOptima Board minutes in which compliance issues are discussed; and/or
- Any other written records of the AOC, or other oversight activities (originals if generated by the Compliance Officer).

Information and Education File

This file shall contain copies of the following (unless originals specified):

- FDR training and attestation records (including attendance records, Affirmation Statements, and the outline of topics covered~~)~~;
- Board M~~m~~ember and Employee training records, attestations, and attendance records are maintained by the Human Resources Department~~HR~~.
- Educational materials provided to Board Members, Employees, and FDRs;
- Notices, F~~f~~raud alerts, and/or federal and state laws and regulations which have been posted on bulletin boards, placed in payroll stuffers, or sent via print or electronic communication (and the dates and locations of such notices); and/or
- All other written records of training activities.

Monitoring, Enforcement, and Response File

This file shall contain copies of the following (unless originals specified):

- Records relating to c~~C~~ompliance reports including reports to the Compliance and Ethics Hotline and/or to the Compliance Officer (originals);
- Records relating to periodic monitoring and auditing of the Compliance Program (originals);
- Records relating to Board Member, Employee, and FDR Participation Status Review or

background checks (originals except where FDRs perform Participation Status Reviews);

- Records relating to established periodic monitoring mechanisms;
- All documents pertaining to the enforcement of the Compliance Program, including, investigations and disciplinary and/or corrective actions; and/or
- All documents reflecting actions taken after an offense has been detected, and all efforts to deter and prevent future violations.

Privileged File

This file shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. Only the Compliance Officer, legal counsel, and the Compliance Committee, where appropriate, shall have access to its contents. All material in this file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. This file contains the following original documents (except where only a copy is available):

- Records of requests for legal assistance~~,~~ or legal opinion(s)~~,~~ in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the Compliance Officer;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning FDR delegation agreement interpretations and remedies available to CalOptima.

Document Retention

All of the documents to be maintained in the filing system described above shall be retained for no less than ten~~five~~ (~~5~~10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract.

CalOptima shall maintain the documentation required by HIPAA for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) Policies and Procedures (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by HIPAA; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under HIPAA; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, ~~Section~~ §164.414(b).

Appendix A

Code of Conduct

Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable laws.	**Transparent, Legal and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board Members, Employees and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, Employees and Contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the fraud, waste and abuse laws. CalOptima is committed to the detection, prevention, and reporting of fraud, waste and abuse. CalOptima is also responsible for ensuring that Board members, Employees and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste and Abuse Plan and policies describe examples of potential fraud, waste and abuse and discuss Employee and Contractor FWA obligations and potential sanctions arising from relevant federal and state FWA laws. CalOptima expects and requires that its Board members, Employees, and Contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws. **Political Activities** CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, Employees and Contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, Employees, and Contractors must comply with applicable antitrust, unfair competition and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.

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Code of Conduct

Principle	Standard
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and Contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of Member care. Employees and Contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and Contractors shall provide culturally, linguistically and sensory appropriate services to CalOptima members to ensure effective communication regarding diagnosis, medical history and treatment, and health education. **Disabled Member Access** CalOptima's Facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled Members. **Emergency Treatment** Employees and Contractors shall comply with all applicable guidelines, policies and procedures and law governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its Physician Groups, its Health Networks and Third Party Administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the State Hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and Contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima Policies and applicable law.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, Employees and Contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees attorneys, and auditors. No Board member, Employee, or Contractor shall make false or misleading statements to any members and/or persons or entities doing business with CalOptima or about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable law and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all regulatory agencies and accrediting bodies in a direct, open and honest manner. Employees and Contractors shall not take action with regulatory agencies and accrediting bodies that is false or misleading.

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Code of Conduct

Principle	Standard
Public Integrity CalOptima and its Board members and Employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Policies. **Public Funds** CalOptima, its Board members, and Employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and Employees shall comply with applicable law and CalOptima Policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and Employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
Confidentiality Board members, Employees, and Contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable law.	**No Personal Benefit** Board members, Employees and Contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at or engaged by CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, Employees and Contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws and CalOptima policies and procedures. **Personnel Files** Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable law. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, Contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall also safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.

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Code of Conduct

Principle	Standard
Business Relationships Business transactions with vendors, Contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, Employees, and Contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving any form of bribe or other improper payment is prohibited. Board members, Employees, Contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima or CalOptima members. **Gifts to CalOptima** Board members and Employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima Policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima Policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima. **Third-Party Sponsored Events** CalOptima's joint participation in Contractor, vendor or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima Policies on this subject. In no event, shall CalOptima participate in any joint Contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at Contractor, vendor or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima Policies. **Provision of Gifts to Government Agencies** Board members, Employees and Contractors shall not offer or provide any money, gifts or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.

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Code of Conduct

Principle	Standard
Conflicts of Interests Board members and Employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated Employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and Employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any Contractor, association of Contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any Contractor or association of Contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any Contractor or association of Contractors.
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Rights Act of 1964. Board members, Employees and Contractors shall not unlawfully discriminate on the basis of race, color, religion, national origin, age, gender, sexual orientation, physical or mental disability or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, Physician Groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that Employees, Contractors, Providers and Suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, Employees, and Contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will monitor the participation status of Employees, individuals and entities doing business with CalOptima by conducting regular exclusion screening reviews in accordance with CalOptima Policies. **Disclosure of Participation Status** Board members, Employees and Contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State Health Care program. Employees and individuals and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action or other matter that could potentially result in their exclusion from participation in any Federal or State health care program.
	Delegated Third Party Administrator Review CalOptima requires that its Health Networks, Physician Groups, and third party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima requires that all Employees, Contractors, Health Networks, participating providers and suppliers who are required to be licensed, credentialed, certified and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration as applicable.

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Code of Conduct

Principle	Standard
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Executive Director, Department of Compliance and/or their Supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information, in accordance with CalOptima Policies and shall comply with instructions on preservation of information and prohibitions on destruction of information issued by Legal Counsel.
Compliance Program Reporting Board members, Employees, and Contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, Employees and Contractors are expected and required to promptly report suspected violations of any statute, regulation or guideline applicable to Federal and/or State health care programs or of CalOptima's own Policies in accordance with CalOptima's reporting Policies and its Compliance Plan. Such reports may be made to a Supervisor, the Executive Director, Office of Compliance. Reports can also be made to CalOptima's hotline number below. Persons making reports to the hotline can do so on an anonymous basis **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, Policies and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's discretion, range from oral correction to termination in accordance with CalOptima's Policies. In addition, failure to comply may result in the imposition of civil, criminal or administrative fines on the individual or entity and CalOptima or exclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, Employees, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination or harassment or compliance concerns or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors and law enforcement agencies. **Certification** All Board members, Employees and Contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable Policies.

Back to Agenda

Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain Covered Services.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M04	Using a Covered Service for purposes other than the purpose for which it was described including use of such Covered Service.	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive Covered Services.	Hotline reports; internal reports; reports by Health Networks
M07	Other (please specify).	Any source
M08	Member Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software
M09	Doctor Shopping.	PBM reports; data analytics; claims data; encounter data; FWA software
M10	Altered Prescription.	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software

Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded provider list
P02	Submission of claims for Covered Services that are substantially and demonstrably in excess of any individual's usual charges for such Covered Services.	PBM reports; data analytics; claims data; encounter data; FWA software
P03	Submission of claims for Covered Services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline
P04	Submission of claims for Covered Services that are in excess of the quantity that is Medically Necessary.	PBM reports; data analytics; claims data; encounter data; FWA software
P05	Submission of claims for Covered Services that are that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software
P06	Submission of claims for Covered Services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software
P07	Submission of claims for Covered Services that are submitted for payment to both CalOptima and another third party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI
P08	Charging a member in excess of allowable co-payments and deductibles for Covered Services.	Member report; hotline report; oversight audits
P09	Billing a member for Covered Services without obtaining written consent to bill for such services.	Member report; hotline report; oversight audits
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process
P11	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a member.	Hotline report; oversight report
P12	Failure to register billing intermediary with the Department of Health Services.	Oversight audit; report by regulatory body; hotline

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P13	False certification of Medical Necessity.	Medical record review; claims data; encounter data; FWA software
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software
P15	False or inaccurate Minimum Standards or credentialing information.	Hotline; credentialing or contracting process
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statues or regulations.	Medical record review; claims data; encounter data; FWA software
P17	Other (please specify).	Any source
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software
P19	Billing Medi-Cal Member for Services.	Member report; hotline report; oversight audits
P20	Durable Medical Equipment- Covered Services that are not actually provided to beneficiary.	Member report; hotline report; oversight audits; verification survey

Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain services	Employees obtaining services on a Member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling Member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for Covered Services that are not actually provided to the Member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using Member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

Appendix E

AFFIRMATION STATEMENTS

CalOptima
AFFIRMATION STATEMENT-SUPERVISORS

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

I understand that it is my responsibility to respond to questions from employees under my direct supervision regarding the Compliance Plan, Code of Conduct, or applicable Policies and Procedures. If I am unable to respond to questions from employees under my direct supervision, I will refer them to the Compliance Officer. In addition, I understand that if an employee under my direct supervision reports a violation or suspected violation of CalOptima's Compliance Program to me, I will escalate and report the issue to the Compliance Officer.

By signature below, I also certify that I have completed the Compliance Training as indicated:

I attended the initial Compliance Training Session on _____.

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-EMPLOYEES

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures specific to my job duties and responsibilities as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the Compliance Training Session on _____:

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-FDRs

I have received and read a copy of the Compliance Plan, Code of Conduct, and applicable Policies and Procedures relevant to the delegated activities, and I understand, acknowledge, and agree to abide by its contents and requirements.

I will disseminate the Compliance Plan, Code of Conduct, and applicable Policies and Procedures to those employees and agents who will furnish items or services to CalOptima under the Contractor Agreement.

_____
Print Name

_____
Signature

_____
Title

_____
Company

_____
Date

SIGN, DATE AND RETURN TO CalOptima SUPERVISOR

CalOptima

AFFIRMATION STATEMENT-BOARD MEMBERS

I have received and read a copy of the Compliance Plan, the Code of Conduct, and applicable Policies and Procedures, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the initial or regular training as indicated:

I attended the initial Compliance Training Session on _____.

I attended the annual Compliance Training Session on _____.

_____

Print Name

_____

Signature

_____

Date

RETURN TO THE COMPLIANCE OFFICER

GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit") means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima members" or "members") means a beneficiary who is enrolled in a CalOptima Program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, and the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards

governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consists of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks and decisions on behalf of the original party. The original party remains liable for compliance for compliance and fulfillment of any and all rules, requirements and obligations pertaining to the delegated functions.

~~Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.~~

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Downstream Entity ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or Employees ("Employee" or "Employees") means any and all employees of CalOptima, including all Ssenior ~~management~~Management, officers, ~~managers~~Managers, ~~supervisors~~ Supervisors and other employed personnel, as well as temporary ~~employees~~ Employees and volunteers.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to 3 times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State health care programs") means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.

Fraud ("F~~f~~raud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network or Health Networks ("Health Network" or "Health Networks") means the contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Monitoring Activities ("Monitoring") means regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Overpayment ("Overpayment") means a payment disbursed in excess amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating providers and suppliers ("participating providers and suppliers") include all health care providers and suppliers (e.g. physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies etc.) that receive reimbursement from CalOptima or its Health Networks for items or services furnished to Members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the health networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, or otherwise ineligible to participate in Federal and/or State Health Care Programs as provided in CalOptima Policies and Procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board members, Employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, or otherwise ineligible to participate in Federal and/or State Health Care Programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written Policies and Procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Related Entity ("Related Entity") means any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Sanction ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

Senior Management ("Senior Management") means any Employee whose position title is Chief Officer, Executive Director, or Director of one (1) or more departments.

Sub-delegation ("Sub-delegation") means the process by which a First Tier Entity expressly grants, by formal agreement, to a Downstream Entity the authority to carry out one or more functions that would otherwise be required to be performed by the First Tier Entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an Employee in a position representing CalOptima who has one or more Employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima Employee that is the designated liaison for that contractor.

Third Party Administrator ("TPA") means a Contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Orange County Health Authority

dba CalOptima

2018 Compliance Plan

(Revised December 2017)

Document maintained by:
Silver Ho
CalOptima Compliance Officer

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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations and rules, including those pertaining to Medi-Cal, Medicare, PACE (Program of All-Inclusive Care for the Elderly), MSSP (Multipurpose Senior Services Program), and other CalOptima programs.

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and monitoring responsibilities related to CalOptima's First Tier, Downstream, and Related Entities (FDRs), such as health networks, physician groups, participating providers, suppliers, pharmacy benefit manager (PBM), and consultants. The term FDR is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS). Such persons/entities, referred to as FDR herein, include those that directly contract with CalOptima and those that are Downstream or Related Entities (i.e. subcontracts) with CalOptima's First Tier Entities.

CalOptima has developed a comprehensive Compliance Program applicable to all of CalOptima's Programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "OneCare"), its Medicare-Medicaid Plan (MMP referred to as "OneCare Connect"), PACE, and MSSP. The Compliance Program incorporates all of the elements of an effective Compliance Program as recommended by the Office of the Inspector General (OIG) and required by CMS regulations. The Compliance Program is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that CalOptima Board Members, Employees, and FDRs conduct themselves in accordance with the requirements of CalOptima's Compliance Program.

B. THE COMPLIANCE PLAN

This Compliance Plan sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently monitor adherence to all applicable laws, regulations, and guidelines. The Compliance Plan addresses the fundamental elements of an effective Compliance Program and identifies how CalOptima is implementing each of the fundamental elements of an effective Compliance Program in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the Compliance Plan is designed to provide guidance and to ensure that CalOptima's operations and the practices of its Board Members, Employees, and FDRs comply with contractual requirements, ethical standards, and applicable law.

This Compliance Plan is adopted by the Governing Body. It was developed and is managed by the Executive Director of Compliance (referred to hereinafter as the "Compliance Officer") with the Compliance Committee. Because the complex laws governing CalOptima and its programs are constantly evolving, the Compliance Plan may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board Members, Employees, and FDRs are expected to review and adhere to the requirements and standards set forth in the Compliance Plan, the Code of Conduct, and all related Policies and Procedures, as may be amended. Furthermore, Board Members, Employees, and FDRs are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a Board Member, Employee, and/or FDR has/have any questions about the application, or implementation, of this Compliance Plan, or questions related to the Code of Conduct or CalOptima Policies and Procedures, he or she should seek guidance from the Compliance Officer and/or the CalOptima Office of Compliance.

I. WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable federal and state standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of Board Members, Employees, and FDRs, CalOptima develops, maintains, and distributes its written standards in the form of this Compliance Plan, a separate Code of Conduct, and written Policies and Procedures.

a. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to CalOptima Board Members, Employees, and FDRs. This Compliance Plan also includes a comprehensive section articulating CalOptima's commitment to preventing Fraud, Waste & Abuse (FWA), and setting forth guidelines and procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Programs. The Compliance Plan is available on CalOptima's external website for Board Members and FDRs as well as on CalOptima's internal intranet site, referred to as InfoNet, accessible to all Employees.

b. Policies and Procedures

CalOptima also developed written Policies and Procedures to address specific areas of CalOptima's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima can efficiently monitor adherence to all applicable laws, regulations, and guidelines. These policies are designed to provide guidance to Board Members, Employees, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, Employees, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Compliance Officer, or Designee, will ensure that Board Members, Employees, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained in accordance with applicable record retention standards.

The Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's Policies and Procedures are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, meets regularly to review and approve proposed changes and additions to CalOptima's Policies and Procedures. Policies and Procedures are available on CalOptima's internal website and Compliance 360, a separate web portal accessible to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum.

c. Code of Conduct

Finally, the Code of Conduct is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the Code of Conduct is to articulate compliance expectations and broad principles that guide CalOptima Board Members, Employees, and FDRs in conducting their business activities in a professional, ethical, and lawful manner. The Code of Conduct is a separate document from the Compliance Plan and can be found in Appendix A. The Code of Conduct is approved by CalOptima's Board of Directors and distributed to Board Members, Employees, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II. OVERSIGHT

The successful implementation of the Compliance Program requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by CalOptima's Board, the Compliance Officer, the Compliance Committee, the Audit & Oversight Committee, and senior management.

a. Governing Body

The CalOptima Board of Directors, as the Governing Body, is responsible for approving, implementing, and monitoring a Compliance Program governing CalOptima's operations. The CalOptima Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Compliance Officer. The Compliance Officer is an employee of CalOptima, who handles compliance oversight and activities full-time. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the CalOptima Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima and monitoring the status of the Compliance Program to ensure its efficient and successful implementation.

To ensure the CalOptima Board exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's Compliance Program, the CalOptima Board:

- ► Understands the content and operation of CalOptima's Compliance Program;
- ► Approves the Compliance Program, including this Compliance Plan and the Code of Conduct;
- ► Requires an effective information system that allows it to properly exercise its oversight role and be informed about the Compliance Program outcomes, including, but not limited to, results of internal and external audits;
- ► Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the Compliance Program;

- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, Corrective Action Plans, Warning Letters, and/or sanctions;
- Receives regularly scheduled, periodic updates from CalOptima's Compliance Officer and Compliance Committee, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the Compliance Program.

The CalOptima Board reviews the measurable indicators of an effective Compliance Program and remains appropriately engaged in overseeing its efficient and successful implementation; however, the CalOptima Board delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The Executive Director of Compliance serves as the Compliance Officer who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and monitors the day-to-day activities of the Compliance Program. The Compliance Officer reports directly to the CEO and the Compliance Committee on the activities and status of the Compliance Program. The Compliance Officer has authority to report matters directly to the CalOptima Board at any time. Furthermore, the Compliance Officer ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The Compliance Officer interacts with the CalOptima Board, CEO, CalOptima's executive and departmental management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, FDR and internal oversight, Policies and Procedures, and training on compliance activities.

The CalOptima Board delegates the following responsibilities to the Compliance Officer, and/or his/her Designee(s):

- Chair the Compliance Committee, which shall meet no less than quarterly and assists the Compliance Officer in fulfilling his/her responsibilities;
- Ensure that the Compliance Program, including this Compliance Plan and Policies and Procedures, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected Board Members, Employees, and FDRs, as appropriate;
- Oversee and monitor the implementation of the Compliance Program, and provide regular reports no less than quarterly to the CalOptima Board and CEO summarizing all efforts, including, but not limited to, the Compliance Committee's efforts to ensure adherence to the

Compliance Program, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and audit activities;

- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential FWA received from any source through any reporting method;
- Design, coordinate, and/or conduct regular internal audits to ensure the Compliance Program is properly implemented and followed, in addition to verifying all appropriate financial and administrative controls are in place;
- Develop and implement an annual schedule of Compliance Program activities for each of CalOptima's Programs, and regularly report CalOptima's progress in implementing those plans to the appropriate Board Committee and/or to the Board of Directors;
- Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or FWA issues, including facilitating any documentation or procedural requests by such agency/ies;
- Oversee and monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., DHCS and CMS) and consult with legal counsel, as necessary;
- Create and coordinate educational training programs and initiatives to ensure that the CalOptima Board, Employees, and FDRs are knowledgeable about CalOptima's Compliance Program, including the Code of Conduct, Policies and Procedures, and all current and emerging applicable statutory and regulatory requirements;
- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate Corrective Action Plans, Sanctions, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and
- Coordinate with CalOptima departments and FDRs to ensure exclusion screening (including through the OIG List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), and Medi-Cal Suspended & Ineligible (S&I) Provider List has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The Compliance Committee, chaired by the Compliance Officer, is composed of CalOptima's senior management and operational staff, as designated by the CEO. The members of the Compliance Committee serve at the discretion of the CEO and may be removed, or added, at any time. The role of the Compliance Committee is to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the Compliance Program.

The CalOptima Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the CalOptima Board;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges);
- Review and Monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
- Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the Compliance Officer to ensure the adequacy of the Compliance Program;
- Review, approve, and/or update Policies and Procedures to ensure the successful implementation and effectiveness of the Compliance Program consistent with regulatory, legal, and contractual requirements;
- Recommend and monitor the development of internal systems and controls to implement CalOptima's standards and Policies and Procedures as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Compliance Officer accordingly;
- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports of Monitoring and Auditing of areas in which CalOptima is at risk of program non-compliance and/or potential FWA, and ensure CAPs and ICAPs are implemented and Monitored for effectiveness;
- Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its FDRs conduct activities and operations in compliance with the applicable law and regulations and sound business ethics; and
- Provide regular and ad-hoc status reports of compliance with recommendations to the CalOptima Board of Directors.

d. Audit & Oversight Committee (AOC)

The Audit & Oversight Committee (AOC) is a subcommittee of the Compliance Committee and is chaired by the Director of Audit & Oversight. The AOC is responsible for overseeing the delegated and internal activities of CalOptima. The Compliance Committee has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in the AOC charter. In addition to the monthly scheduled meetings, the AOC may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the AOC presented are approved by a quorum. A quorum is defined as one (1) over fifty percent (50%). AOC may approve and/or implement Corrective Act Plans (CAPs); however, recommendations for FDR sanctioning and/or de-delegation are submitted to the Compliance Committee for final approval. The AOC also contributes to external reviews and accreditation audits, such as the National Committee for Quality Assurance (NCQA).

Responsibilities of the Audit & Oversight Committee with regard to FDRs include:

- Annual review, revision, and approval of the audit tools;
- Review findings of the pre-delegation audit and readiness assessment to evaluate a potential FDR's ability to perform the delegated function(s);
- Review and approve potential FDR entities for delegation of functions;
- Ensure written agreements with each delegated FDR clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- Conduct formal, ongoing evaluation and monitoring of FDR performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite audit;
- Ensure all Downstream and Related Entities are monitored in accordance with CalOptima oversight procedures;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage Corrective Action Plans (CAPs) for compliance issues;
- Propose Sanctions, subject to the Compliance Committee's approval, if an FDR's performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of delegation, to the Compliance Committee for unresolved issues of compliance.

Responsibilities of the Audit & Oversight Committee with regard to internal business functions include:

- Annual review, revision, and approval of the Audit & Oversight Department Program Description and audit tools;
- Conduct formal, ongoing evaluation and monitoring of internal business areas' performance and compliance through review of periodic reports submitted, ongoing monitoring, and findings of the annual audit;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage Corrective Action Plans (CAPs) for compliance issues.

e. Senior Management

The CEO and other executive management of CalOptima shall:

- Ensure that the Compliance Officer is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective Compliance Program;
- Receive periodic reports from the Compliance Officer of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and

- Be advised of all governmental compliance and enforcement findings and activity, including audit findings, notices of non-compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III. TRAINING

Education and training are critical elements of the Compliance Program. CalOptima requires that all Board Members, Employees, and FDRs complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's Code of Conduct, compliance obligations, and relevant laws, and FWA, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing seniors and people with disabilities (SPD) and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the Compliance Program, and which courses are updated regularly to ensure that employees are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The Compliance Officer is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The Compliance Officer and the CalOptima management staff are responsible for ensuring that Board Members, Employees, and FDRs complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's Code of Conduct to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt, review, and understanding of the Code of Conduct within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each person's files, as required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires Board Members, Employees, and FDRs, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the Compliance Program; FWA training; HIPAA privacy and security requirements; ethics; and a high level overview of the Medicare and Medi-Cal Programs. CalOptima's training courses cover CalOptima's commitment to compliance with federal and state laws and regulations, contractual obligations, internal policies, and ethics. Elements of the Compliance Program are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or FWA issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's HIPAA privacy and security training course covers the administrative, technical, and physical safeguards necessary to secure members' protected health information(PHI) and personally identifiable information (PII).

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the Compliance Program requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each Employee. Board Members and FDRs are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some FDRs may be exempt or deemed to have met the FWA training and education requirement if the FDR has met the CMS requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically and records of completion are maintained for each individual as required by law.

c. Additional Training

The Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the Compliance Program. These training opportunities are available to managers and Employees depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing managers the tools and resources to train and share the information with Employees in their respective departments. If additional training related to FWA is required, the Compliance Officer will develop relevant materials.

Employees have access through CalOptima's internal intranet website (referred to as the "InfoNet") to CalOptima's Policies and Procedures governing the Compliance Program and pertinent to their respective roles and responsibilities. Employees may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board Members receive a copy of the Compliance Plan, Code of Conduct, and Policies and Procedures pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the CalOptima Board. Board Members may receive additional compliance training related to the CalOptima Board's role in overseeing and ensuring organizational compliance with CalOptima's Compliance Program.

The Code of Conduct and Policies and Procedures pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to FDRs upon commencement of the FDR contract. FDRs are required to disseminate copies of the Code of Conduct and Policies and Procedures to their employees, agents, and/or Downstream Entities. CalOptima may also develop compliance training and education presentations and/or roundtables for specified FDRs.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the Compliance Program and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to Policies and Procedures, contact information for the Compliance Officer, relevant federal and state fraud alerts and policy letters, pending/new legislation reports, and advisory bulletins from the Compliance Officer to CalOptima Board Members, Employees, FDRs, and members, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the CalOptima Board, FDRs, Employees, individual CalOptima departments, and members.
- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to Board Members, Employees, and FDRs, which contains CalOptima's updated Policies and Procedures.
- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to Board Members, Employees, FDRs, and Members.
- Electronic Mail – The CEO, Compliance Officer, or their respective Designee, periodically sends out email communications and/or alerts to Board Members, Employees, FDRs and/or Members, as applicable.
- CalOptima's Internal Intranet Website – CalOptima maintains an internal intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to Employees.
- CalOptima's Compliance Internal Website – The Office of Compliance maintains an internal department website accessible to CalOptima Employees to communicate different Compliance initiatives, notices, key documents and forms, and updates to the Compliance Program, Code of Conduct, and/or Policies and Procedures.
- Postings – The Office of Compliance posts information on how to report potential issues of non-compliance and FWA throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima Employees.
- Written Reports – The Compliance Officer, in coordination with the CEO and Compliance Committee, prepares written monthly reports concerning the status of the Compliance Program to be presented to the CalOptima Board.
- Direct Contact with the Compliance Officer - Board Members, Employees, and FDRs can obtain additional compliance information directly from the Compliance Officer. Any questions, which cannot be answered by the Compliance Officer, shall be referred to the Compliance Committee.

b. Reporting Mechanisms

CalOptima Board Members, Employees, and FDRs have an affirmative duty and are directed in CalOptima's Code of Conduct and Policies and Procedures to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by Board Members, Employees, and/or FDRs to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an FDR contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or FWA incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and FWA issues are also provided to Board Members, Employees, FDRs, and Members in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or FWA.

Upon receipt of a report through one (1) of the listed mechanisms, the Compliance Officer shall follow appropriate Policies and Procedures to promptly review, investigate, and resolve such matters. The Compliance Officer shall monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. Report Directly to a Supervisor or Manager

CalOptima employees are encouraged to contact their immediate Supervisor, or Manager, when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. The Supervisor, or Manager, will promptly escalate the report to the Compliance Officer for further investigation and reporting to the CalOptima Compliance Committee. If an Employee is concerned that his/her Supervisor or Manager did not adequately address his/her report or complaint, the Employee may go directly to the Compliance Officer, or the CEO.

2. Call the Compliance and Ethics Hotline

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with Spanish and English capability, in which CalOptima may receive anonymous issues on a confidential basis. Members are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or FWA issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary

action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all Board Members, Employees, FDRs, and Members. Members also have access to the Compliance Officer through the Compliance and Ethics Hotline and/or the right to contact the OIG Compliance Hotline directly.

3. Report Directly to the Compliance Officer

The Compliance Officer is available to receive reports of suspected or actual compliance violations, or FWA issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from Board Members, Employees, FDRs and members. The Compliance Officer may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. FDRs are generally contractually obligated to report suspected Fraud and Abuse to CalOptima pursuant to regulatory and contractual requirements.

4. Report Directly to Office of Compliance

Reports may be made directly to CalOptima's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA 92868

5. Confidentiality and Non-Retaliation

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and Members. CalOptima's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima InfoNet and website, as well as sending periodic member notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the Compliance Officer will review and enforce disciplinary and/or other Corrective Action Plans for violations, as appropriate, with the approval of the Compliance Committee.

V. ENFORCEMENT AND DISCIPLINARY STANDARDS

Board Members, Employees, and FDRs are provided copies of CalOptima's Code of Conduct and the Compliance Plan and have access on CalOptima's internal and external website to applicable Policies and Procedures, including, but not limited to, CalOptima's Progressive Discipline Policy and Office of Compliance Policies addressing Corrective Action Plans and Sanctions. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance or unethical behavior is confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board Members, Employees, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures, including CalOptima's Progressive Discipline Policy, as applicable. Board Members, Employees, and FDRs may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures and/or contracts; or
- Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one (1) of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima's HIPAA privacy and security policies, including actions that harm the privacy of members, or the CalOptima information systems that store member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, Sanctions, and/or termination, depending on the nature and severity of the conduct, or behavior. Board Members may be subject to removal, Employees are subject to discipline, up to and including termination, and FDRs may be sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative Sanctions and/or penalties. Further violations could lead to suspension, or exclusion, from participation in Federal and/or State

Health Care Programs.

CalOptima Employees shall be evaluated annually based on their compliance with CalOptima's Compliance Program. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

VI. MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with monitoring and auditing are identified through a combination of activities: risk assessments, Audit & Oversight and Compliance Committee discussions and decisions, and internal and external reporting. Through monitoring, auditing, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The Compliance Officer will collaborate with the Compliance Committee to identify areas of focus for monitoring and auditing potential non-compliant activity and FWA issues. A Compliance Risk Assessment will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of FDRs. Operations and processes will be evaluated based on: (1) deficiencies found by regulatory agencies; (2) deficiencies found by internal and external audit and monitoring reports; (3) the institution of new or updated procedures; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by CMS and the OIG Work Plan shall be used as resources to evaluate operational risks.

The Compliance Officer will work with the Chief Operating Officer, or his/her Designee, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring monitoring and auditing. Those operational areas determined to be high risk may be subject to more frequent monitoring and auditing, as well as additional reporting requirements. The risk assessment process will be managed by the Compliance Officer, or his/her Designee, and presented to the Audit & Oversight Committee (AOC), and subsequently to the Compliance Committee, for review and approval. Monitoring plans will be developed in collaboration with the operational areas, and focused audits may be scheduled based on the results of the ongoing monitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine monitoring and auditing activities to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Policies and Procedures to protect against non-compliance and potential FWA in CalOptima Programs. Monitoring activities are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An audit is a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., Policies and Procedures, laws and regulations) used as base measures. As part of the monitoring process, CalOptima has created a dashboard, which is a monitoring tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with monitoring operations and outcomes and to identify areas in need of targeted auditing on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be

used to develop monitoring and auditing work plans. Monitoring and auditing work plans are used to detect potential areas of risk and/or non-compliant activity. The monitoring and auditing work plans are subject to daily updates and additions, and are therefore, working documents. The Compliance Officer, in collaboration with the AOC and Compliance Committee, develops the monitoring and auditing work plans to address the risks associated with each of CalOptima's Programs.

The Compliance Officer will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate auditing and monitoring activities. Audits for each operational area will be conducted throughout the year consistent with the monitoring and auditing work plans. The Compliance Officer will coordinate the audits with internal audit staff, and, in some cases, with the assistance from an outside vendor. Audit methodologies shall be consistent with regulatory requirements and standards. All audits will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the audit review is completed, the audit team will communicate the results to the Compliance Officer and propose follow up corrective action(s), if necessary. The Compliance Officer will provide reports to the CEO and the Compliance Committee concerning the results of the audits. The AOC reports to the Compliance Officer and the Compliance Committee on audits that involve FDRs as discussed below. If Fraud, Waste, or Abuse (FWA) issues are identified during an audit, the matter will be further investigated and resolved in a timely manner. In addition, an audit of the Compliance Program and its effectiveness should occur at least annually, and the results shall be reported to the CalOptima Board.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to CMS, DHCS, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight monitoring and auditing process of FDRs who perform delegated activities. The processes that CalOptima implements to oversee, monitor, and audit FDRs are incorporated into CalOptima's written Policies and Procedures, including processes involving pre-contractual evaluations and audits of First Tier Entities. CalOptima may implement Corrective Action Plans, Sanctions, and/or revoke its delegation of duties (in a manner permitted under the contract) if CalOptima determines that an FDR is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The Compliance Officer, or his/her Designee, determines the process for monitoring delegated FDRs and develops the annual monitoring and audit calendar in order to validate compliance with contractual standards and regulatory requirements. The AOC is responsible for overseeing all of the delegated activities and will review the pre-delegation audit, ensure the annual review of FDRs for delegated functions are completed, conduct formal on-going evaluation of FDR performance and compliance, ensure Downstream and Related Entitles are monitored, and impose Corrective Action Plans and/or Sanctions if the FDR's performance fails to meet statutory and contractual standards and requirements. The AOC may recommend termination of delegation to the Compliance Committee for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. Initial Evaluation

Prior to executing a contract or delegation agreement with a potential FDR, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's Policies and Procedures, is completed to determine the ability of the potential FDR to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, CMS, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not excluded in the OIG List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Award Management (SAM), or the DHCS Medi-Cal Provider Manual from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the Audit & Oversight Committee and subsequently the Compliance Committee for review and/or approval.

2. Contracting with FDRs

Once an entity has been approved, the delegation agreement specifies the activities CalOptima delegates to the FDRs, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and audits, and remedies, including disciplinary actions, available to CalOptima. Prior to any sub-delegation to any Downstream or Related Entity, a First Tier Entity must obtain approval from CalOptima. CalOptima determines who will directly monitor the Downstream or Related Entity's compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the FDR and their contractually delegated area(s). Furthermore, FDRs will be required to complete, sign, and return attestation forms confirming the FDR's compliance with new hire and annual training and education requirements, which includes courses on general compliance and FWA as well as exclusion screening and FWA reporting obligations.

3. Annual Risk Assessment

The Compliance Officer, or his/her Designee, will conduct an annual comprehensive risk assessment to determine the FDR's vulnerabilities and high risk areas. High risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed high risk, or vulnerable, is presented to the AOC for suggested follow-up audit. FDRs determined to be high risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Compliance Officer, or his/her Designee, and presented to the AOC and subsequently to the Compliance Committee for review and approval.

4. FDR Performance Reviews and Audits

CalOptima conducts a periodic comprehensive performance review of the FDR's ability to provide delegated services in accordance with contractual standards and applicable state, CMS, and accreditation requirements, as further detailed in CalOptima's Policies and Procedures. CalOptima may conduct audits of FDRs at any time. Such audits may include an evaluation of the FDR's training and education program and materials covering general compliance and FWA, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High risk FDRs, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual audit calendar; however, CalOptima does not limit its auditing schedule to only high risk FDRs.

If CalOptima has reason to believe the FDR's ability to perform a delegated function is compromised, an additional focused audit may be performed. The Compliance Officer may also recommend focused audits upon evaluation of non-compliant trends or reported incidents. The results of these audits will be reported to the AOC and then to the Compliance Committee.

A focused audit may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- Failure to comply with regulatory requirements and/or the CalOptima's service level performance indicators;
- Failure to comply with a Corrective Action Plan;
- Reported or alleged Fraud, Waste, and/or Abuse;
- Significant policy variations that deviate from the CalOptima or state, CMS, or accreditation requirements;
- Bankruptcy, or impending bankruptcy, which may impact services to members (either suspected or reported);
- Sale, merger, or acquisition involving the FDR;
- Significant changes in the management of the FDR; and/or
- Changes in resources which impact CalOptima's and/or the FDR's operations.

5. Corrective Actions and Additional Monitoring and Auditing

The Compliance Officer shall submit regular reports of all monitoring, audit, and corrective action activities to the Compliance Committee. In instances where non-compliance is identified, a Corrective Action Plan shall be developed by the FDR and reviewed and approved by the Compliance Officer, or his/her Designee. Every Corrective Action Plan is presented to the AOC for review. Supplemental and focused audits of FDRs, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement Sanctions or require remediation by an FDR for failure to fulfill contractual obligations including development and implementation of a Corrective Action Plan. Failure to cooperate with CalOptima in any manner may result in termination of the delegation agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's auditing process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the auditing processes, including Policies and Procedures, audit tools, and audit findings, to ensure all regulatory requirements are being audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- The central database of all pending, active, and terminated FDRs to monitor and track functions, performance, and audit schedules;
- Implementation of an escalation process for compliance/performance issues;
- Implementation of a process for validation of audit tools;
- Implementation of a process for noticing FDRs and functional areas of Corrective Action Plans;
- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding delegation standards, auditing, and monitoring FDR performance; and/or
- Implementation a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of FDR performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight audits completed within twelve (12) months; and
- Corrective Action Plans (CAPs) completed within the established timeframe.

f. Regular Exclusion Screening

As detailed in CalOptima's Policies and Procedures, CalOptima performs Participation Status Reviews by reviewing the OIG –LEIE, the GSA–SAM, and DHCS Medi-Cal Suspended & Ineligible Provider Lists upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, Employees, and/or FDRs are not excluded, or do not become excluded from participating in Federal and/or State health care programs. Board Members, Employees, and FDRs are required to disclose their Participation Status as part of their initial appointment, employment, commencement of the contract and registration/application processes and when Board Members, Employees, and FDRs receive notice of a suspension, exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima also

requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

The Compliance Officer will review reports from Employees responsible for conducting the Participation Status Reviews to ensure Employees record and maintain the results of the reviews and notices/disclosures. Employees shall immediately notify the Compliance Officer of affirmative findings of a person, or entity's, failure to meet the Participation Status Review requirements. If CalOptima learns that any prospective, or current, Board Member, Employee, or FDR has been proposed for exclusion or excluded, CalOptima will promptly remove him/her/the FDR from CalOptima's Programs consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of their suspension, exclusion, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. The Compliance Officer will review potential organizational obligations related to the reporting of identified excluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII. RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's Compliance Program and/or FWA issues, the Compliance Officer shall, upon promptly verifying the facts related to the violation or likely violation, notify the Compliance Committee, as appropriate. The Compliance Committee (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, Sanctions, termination of any agreement and/or any other corrective action (including repayment of Overpayments) consistent with applicable Policies and Procedures, subject to consultation with legal counsel and/or notifying the Governing Body, as appropriate;
- Implementing education and training programs for Board Members, Employees, and/or FDRs, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's Compliance Plan, Code of Conduct, and/or relevant Policies and Procedures in an effort to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding compliance matters are appropriately secured.

It is the responsibility of the Compliance Officer and the Compliance Committee to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable Policies and Procedures after considering such recommendations. The Compliance Officer, or his/her Designee, shall monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning Fraud schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims

activity indicates that Fraud may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a Fraud alert is received, CalOptima shall review its delegation agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the delegation agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a Fraud alert. With the issuance of a Fraud alert, CMS places CalOptima on notice (see Title 42, Code of Federal Regulations, §423.505(k)(3)) that claims involving the identified party needs to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged Fraud scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes member complaints, DHCS Audits and Investigations referrals, MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of Federal and/or State health care programs requirements. CalOptima shall also maintain files that contain documented warnings (e.g., Fraud alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, DHCS, CMS, and CMS' designee, regarding monitoring of FDRs within CalOptima's network that DHCS, or CMS, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent Fraud, Waste, and Abuse (FWA) within a CalOptima program. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of FWA activity. CalOptima shall assess all FDRs for potential Overpayments when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return Overpayments consistent with applicable law and regulatory guidance. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of Overpayment determinations to regulatory agencies, as required by law.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima's Compliance Program. FWA activities are implemented and overseen by CalOptima's Compliance Officer in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for FWA investigations. The Compliance Officer reports FWA activities to the CalOptima Compliance Committee, CEO, the CalOptima Board, and regulatory agencies.

CalOptima utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima promptly investigates suspected FWA issues and implements disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Programs is appropriately delivered to Members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

I. TRAINING

As detailed above, FWA training is provided to all Board Members and Employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA. FDRs are also required to complete FWA training, as described above. CalOptima's FWA training provides guidance to Board Members, Employees, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual FWA;
- Examples of the most common types of member FWA (see Appendix B, attached hereto and incorporated herein) and FDR FWA (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima's PACE Program (e.g., suspicious activities suggesting PACE participants or their family members may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in the PACE program, etc.);
- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);

- How to report potential FWA using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for FDRs, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the False Claims Act and CalOptima's requirement to train Employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima shall provide Board Members, Employees, FDRs, and members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II. DETECTION OF FWA

a. Data Sources

In partnership with the Regulatory Affairs & Compliance Department, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of FWA. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. Members, FDRs, Employees, law enforcement and regulatory agencies, and others are able to contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect FWA include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Monitoring and auditing activities;
- Monitoring external health care FWA cases and determining if CalOptima's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and audits.

b. Data Analytics

CalOptima uses technology and data analysis to reduce FWA externally. Using a combination of

industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect FDRs based on billing patterns.

CalOptima also uses the services of an external Medicare Secondary Payer (MSP) vendor to reduce costs associated with its Medicare Advantage Part D program, OneCare, by ensuring that Medicare funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data is analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed in accordance with applicable state or federal law if they meet certain criterion that warrants additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (for example narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the PBM will conduct data mining activities in order to identify potential issues of FWA.

The following trends will be reviewed and flagged for potential FWA, including:

- Over utilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual Coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible

losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected FWA. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM will go through the same risk assessment process. The analysis will be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or makes arrangements to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides a number of refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA actually exists. The following list below highlights common industry indicators and red flags that are used to determine whether or not to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the member/patient's last name.
- Insured's address is the same as the servicing provider.

- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA database and a report is generated and submitted to the Compliance Officer, Compliance Committee, and CEO.

III. INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (Access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU, or a designee, interviews the individual who reported the FWA, affected members and/or FDRs, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership, as necessary;
- Review of member enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the Fraud Tracking System, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking System shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation shall be forwarded to the Compliance Officer and Compliance Committee

for discussion and approval.

IV. FINDINGS, RESPONSE, AND REMEDIATION

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, new policy implementation, and/or criminal or civil action. When the root cause of the potential FWA issue has been identified, the SIU will track and trend the FWA allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether or not disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima's Policies and Procedures, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima Policies and Procedures, CalOptima shall take appropriate disciplinary, or corrective, action against Board Members, Employees, and/or FDRs related to validated instances of FWA. CalOptima will also assess FDRs for potential Overpayments when reviewing and undertaking corrective actions. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, Corrective Action Plans, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the correction action may be applied universally.

V. REFERRAL TO ENFORCEMENT AGENCIES

CalOptima's SIU shall coordinate timely referrals of potential FWA to appropriate regulatory agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS and/or DHCS, as soon as possible after discovery, but no later than ten (10) working days to DHCS after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to MEDIC after a OneCare, OneCare Connect, or PACE case is reported to CalOptima's SIU.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond the CalOptima and involve multiple health plans, multiple states, or widespread schemes;

- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life, or well-being, of CalOptima members; and/or
- Schemes with large financial risk to CalOptima, or its members.

VI. ANNUAL EVALUATION

CalOptima's Compliance Committee shall periodically review and evaluate the FWA activities and its effectiveness as part of the overall Compliance Program monitoring and audit activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Compliance Plan, and other input from applicable sources.

VII. RETENTION OF RECORDS

CalOptima shall maintain reports and summaries of FWA activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of member records containing PHI in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of FWA investigations in a secure and confidential manner, regardless of the outcome of an investigation.

VIII. CONFIDENTIALITY

CalOptima and its FDRs shall maintain all information associated with suspected, or actual, FWA in confidential files, which may only be released in accordance with applicable laws and CalOptima Policies and Procedures. All participants and attendees of CalOptima's Quality Improvement Committee, Compliance Committee, and respective subcommittees, shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the Compliance Program, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the Compliance Program against the elements of an effective Compliance Program as recommended by OIG and required by CMS regulations. The following areas will be reviewed:

- Policies and procedures;
- Compliance Officer and Compliance Committee;
- Training and education of Board Members, Employees, and FDRs;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal monitoring and auditing; and
- Prompt responses to detected offenses.

The Compliance Program will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with Senior Management, the Compliance Committee, and the CalOptima Board. Updates to the Compliance Program will be based on the results of the evaluation and will be referred to the CalOptima Board for review and approval.

E. FILING SYSTEMS

The Compliance Officer shall establish and maintain a filing system (or systems) for all compliance-related documents. The following files shall be established at CalOptima (as applicable):

Compliance Plan, Code of Conduct, and Policies and Procedures File

This file shall contain copies of the following (unless originals specified):

- Compliance Plan and any amendments;
- Any Compliance Program Policies and Procedures issued after the initiation of the Compliance Program;
- Reports to, and Resolutions/Minutes of CalOptima's Board approving the Compliance Program, Compliance Plan, Code of Conduct and/or appointment of the Compliance Officer;
- All non-privileged communications to the Compliance Officer (original);
- All Compliance Committee and CalOptima Board minutes in which compliance issues are discussed; and/or
- Any other written records of the AOC, or other oversight activities (originals if generated by the Compliance Officer).

Information and Education File

This file shall contain copies of the following (unless originals specified):

- FDR training and attestation records (including attendance records, Affirmation Statements, and the outline of topics covered;
- Board Member and Employee training records, attestations, and attendance records are maintained by the Human Resources Department.
- Educational materials provided to Board Members, Employees, and FDRs;
- Notices, Fraud alerts, and/or federal and state laws and regulations which have been posted on bulletin boards, placed in payroll stuffers, or sent via print or electronic communication (and the dates and locations of such notices); and/or
- All other written records of training activities.

Monitoring, Enforcement, and Response File

This file shall contain copies of the following (unless originals specified):

- Records relating to compliance reports including reports to the Compliance and Ethics Hotline and/or to the Compliance Officer (originals);
- Records relating to periodic monitoring and auditing of the Compliance Program (originals);
- Records relating to Board Member, Employee, and FDR Participation Status Review or

background checks (originals except where FDRs perform Participation Status Reviews);

- Records relating to established periodic monitoring mechanisms;
- All documents pertaining to the enforcement of the Compliance Program, including, investigations and disciplinary and/or corrective actions; and/or
- All documents reflecting actions taken after an offense has been detected, and all efforts to deter and prevent future violations.

Privileged File

This file shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. Only the Compliance Officer, legal counsel, and the Compliance Committee, where appropriate, shall have access to its contents. All material in this file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. This file contains the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinion(s) in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the Compliance Officer;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning FDR delegation agreement interpretations and remedies available to CalOptima.

Document Retention

All of the documents to be maintained in the filing system described above shall be retained for no less than ten (10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract.

CalOptima shall maintain the documentation required by HIPAA for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) Policies and Procedures (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by HIPAA; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under HIPAA; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, §164.414(b).

Appendix A

Code of Conduct

Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable laws.	**Transparent, Legal and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board Members, Employees and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, Employees and Contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the fraud, waste and abuse laws. CalOptima is committed to the detection, prevention, and reporting of fraud, waste and abuse. CalOptima is also responsible for ensuring that Board members, Employees and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste and Abuse Plan and policies describe examples of potential fraud, waste and abuse and discuss Employee and Contractor FWA obligations and potential sanctions arising from relevant federal and state FWA laws. CalOptima expects and requires that its Board members, Employees, and Contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws. **Political Activities** CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, Employees and Contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, Employees, and Contractors must comply with applicable antitrust, unfair competition and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.

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Code of Conduct

Principle	Standard
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and Contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of Member care. Employees and Contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and Contractors shall provide culturally, linguistically and sensory appropriate services to CalOptima members to ensure effective communication regarding diagnosis, medical history and treatment, and health education. **Disabled Member Access** CalOptima's Facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled Members. **Emergency Treatment** Employees and Contractors shall comply with all applicable guidelines, policies and procedures and law governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its Physician Groups, its Health Networks and Third Party Administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the State Hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and Contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima Policies and applicable law.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, Employees and Contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees attorneys, and auditors. No Board member, Employee, or Contractor shall make false or misleading statements to any members and/or persons or entities doing business with CalOptima or about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable law and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all regulatory agencies and accrediting bodies in a direct, open and honest manner. Employees and Contractors shall not take action with regulatory agencies and accrediting bodies that is false or misleading.

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Code of Conduct

Principle	Standard
Public Integrity CalOptima and its Board members and Employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Policies. **Public Funds** CalOptima, its Board members, and Employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and Employees shall comply with applicable law and CalOptima Policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and Employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
Confidentiality Board members, Employees, and Contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable law.	**No Personal Benefit** Board members, Employees and Contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at or engaged by CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, Employees and Contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws and CalOptima policies and procedures. **Personnel Files** Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable law. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, Contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall also safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.

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Code of Conduct

Principle	Standard
Business Relationships Business transactions with vendors, Contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, Employees, and Contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving any form of bribe or other improper payment is prohibited. Board members, Employees, Contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima or CalOptima members. **Gifts to CalOptima** Board members and Employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima Policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima Policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima. **Third-Party Sponsored Events** CalOptima's joint participation in Contractor, vendor or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima Policies on this subject. In no event, shall CalOptima participate in any joint Contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at Contractor, vendor or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima Policies. **Provision of Gifts to Government Agencies** Board members, Employees and Contractors shall not offer or provide any money, gifts or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.

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Code of Conduct

Principle	Standard
Conflicts of Interests Board members and Employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated Employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and Employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any Contractor, association of Contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any Contractor or association of Contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any Contractor or association of Contractors.
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Rights Act of 1964. Board members, Employees and Contractors shall not unlawfully discriminate on the basis of race, color, religion, national origin, age, gender, sexual orientation, physical or mental disability or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, Physician Groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that Employees, Contractors, Providers and Suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, Employees, and Contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will monitor the participation status of Employees, individuals and entities doing business with CalOptima by conducting regular exclusion screening reviews in accordance with CalOptima Policies. **Disclosure of Participation Status** Board members, Employees and Contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State Health Care program. Employees and individuals and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action or other matter that could potentially result in their exclusion from participation in any Federal or State health care program.
	Delegated Third Party Administrator Review CalOptima requires that its Health Networks, Physician Groups, and third party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima requires that all Employees, Contractors, Health Networks, participating providers and suppliers who are required to be licensed, credentialed, certified and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration as applicable.

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Code of Conduct

Principle	Standard
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Executive Director, Department of Compliance and/or their Supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information, in accordance with CalOptima Policies and shall comply with instructions on preservation of information and prohibitions on destruction of information issued by Legal Counsel.
Compliance Program Reporting Board members, Employees, and Contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, Employees and Contractors are expected and required to promptly report suspected violations of any statute, regulation or guideline applicable to Federal and/or State health care programs or of CalOptima's own Policies in accordance with CalOptima's reporting Policies and its Compliance Plan. Such reports may be made to a Supervisor, the Executive Director, Office of Compliance. Reports can also be made to CalOptima's hotline number below. Persons making reports to the hotline can do so on an anonymous basis **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, Policies and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's discretion, range from oral correction to termination in accordance with CalOptima's Policies. In addition, failure to comply may result in the imposition of civil, criminal or administrative fines on the individual or entity and CalOptima or exclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, Employees, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination or harassment or compliance concerns or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors and law enforcement agencies. **Certification** All Board members, Employees and Contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable Policies.

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Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain Covered Services.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M04	Using a Covered Service for purposes other than the purpose for which it was described including use of such Covered Service.	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive Covered Services.	Hotline reports; internal reports; reports by Health Networks
M07	Other (please specify).	Any source
M08	Member Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software
M09	Doctor Shopping.	PBM reports; data analytics; claims data; encounter data; FWA software
M10	Altered Prescription.	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software

Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded provider list
P02	Submission of claims for Covered Services that are substantially and demonstrably in excess of any individual's usual charges for such Covered Services.	PBM reports; data analytics; claims data; encounter data; FWA software
P03	Submission of claims for Covered Services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline
P04	Submission of claims for Covered Services that are in excess of the quantity that is Medically Necessary.	PBM reports; data analytics; claims data; encounter data; FWA software
P05	Submission of claims for Covered Services that are that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software
P06	Submission of claims for Covered Services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software
P07	Submission of claims for Covered Services that are submitted for payment to both CalOptima and another third party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI
P08	Charging a member in excess of allowable co-payments and deductibles for Covered Services.	Member report; hotline report; oversight audits
P09	Billing a member for Covered Services without obtaining written consent to bill for such services.	Member report; hotline report; oversight audits
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process
P11	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a member.	Hotline report; oversight report
P12	Failure to register billing intermediary with the Department of Health Services.	Oversight audit; report by regulatory body; hotline

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P13	False certification of Medical Necessity.	Medical record review; claims data; encounter data; FWA software
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software
P15	False or inaccurate Minimum Standards or credentialing information.	Hotline; credentialing or contracting process
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statues or regulations.	Medical record review; claims data; encounter data; FWA software
P17	Other (please specify).	Any source
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software
P19	Billing Medi-Cal Member for Services.	Member report; hotline report; oversight audits
P20	Durable Medical Equipment- Covered Services that are not actually provided to beneficiary.	Member report; hotline report; oversight audits; verification survey

Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain services	Employees obtaining services on a Member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling Member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for Covered Services that are not actually provided to the Member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using Member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

Appendix E

AFFIRMATION STATEMENTS

CalOptima
AFFIRMATION STATEMENT-SUPERVISORS

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

I understand that it is my responsibility to respond to questions from employees under my direct supervision regarding the Compliance Plan, Code of Conduct, or applicable Policies and Procedures. If I am unable to respond to questions from employees under my direct supervision, I will refer them to the Compliance Officer. In addition, I understand that if an employee under my direct supervision reports a violation or suspected violation of CalOptima's Compliance Program to me, I will escalate and report the issue to the Compliance Officer.

By signature below, I also certify that I have completed the Compliance Training as indicated:

I attended the initial Compliance Training Session on _____.

_____	_____
Print Name	Signature
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Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-EMPLOYEES

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures specific to my job duties and responsibilities as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the Compliance Training Session on _____:

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-FDRs

I have received and read a copy of the Compliance Plan, Code of Conduct, and applicable Policies and Procedures relevant to the delegated activities, and I understand, acknowledge, and agree to abide by its contents and requirements.

I will disseminate the Compliance Plan, Code of Conduct, and applicable Policies and Procedures to those employees and agents who will furnish items or services to CalOptima under the Contractor Agreement.

_____
Print Name

_____
Signature

_____
Title

_____
Company

_____
Date

SIGN, DATE AND RETURN TO CalOptima SUPERVISOR

CalOptima

AFFIRMATION STATEMENT-BOARD MEMBERS

I have received and read a copy of the Compliance Plan, the Code of Conduct, and applicable Policies and Procedures, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the initial or regular training as indicated:

I attended the initial Compliance Training Session on _____.

I attended the annual Compliance Training Session on _____.

_____

Print Name

_____

Signature

_____

Date

RETURN TO THE COMPLIANCE OFFICER

GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit") means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima members" or "members") means a beneficiary who is enrolled in a CalOptima Program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, and the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards

governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consists of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks and decisions on behalf of the original party. The original party remains liable for compliance for compliance and fulfillment of any and all rules, requirements and obligations pertaining to the delegated functions.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Downstream Entity ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or Employees ("Employee" or "Employees") means any and all employees of CalOptima, including all Senior Management, officers, Managers, Supervisors and other employed personnel, as well as temporary Employees and volunteers.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to 3 times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State health care programs") means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network or Health Networks ("Health Network" or "Health Networks") means the contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk

Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Monitoring Activities ("Monitoring") means regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Overpayment ("Overpayment") means a payment disbursed in excess amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating providers and suppliers ("participating providers and suppliers") include all health care providers and suppliers (e.g. physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies etc.) that receive reimbursement from CalOptima or its Health Networks for items or services furnished to Members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the health networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, or otherwise ineligible to participate in Federal and/or State Health Care Programs as provided in CalOptima Policies and Procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board members, Employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, or otherwise ineligible to participate in Federal and/or State Health Care Programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written Policies and Procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Related Entity ("Related Entity") means any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Sanction ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

Senior Management ("Senior Management") means any Employee whose position title is Chief Officer, Executive Director, or Director of one (1) or more departments.

Sub-delegation ("Sub-delegation") means the process by which a First Tier Entity expressly grants, by formal agreement, to a Downstream Entity the authority to carry out one or more functions that would otherwise be required to be performed by the First Tier Entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an Employee in a position representing CalOptima who has one or more Employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima Employee that is the designated liaison for that contractor.

Third Party Administrator ("TPA") means a Contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Attachment 3: Summary of Proposed Actions for Office of Compliance Policies and Procedures

Table 1: Revisions to the Office of Compliance Policies and Procedures

The following table lists the proposed revisions to the CalOptima Office of Compliance policies and procedures, by department.

Department	Policy	Summary of Change(s)	Reason for Change(s)
Audit & Oversight	GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities	▪ Aligned with CalOptima's Quality Assurance Program ▪ Clarified the Delegated Entity's credentialing and recredentialing responsibilities ▪ Added details to information exchange between delegated entities and CalOptima ▪ Incorporated the OneCare and OneCare Connect programs ▪ Updated references	Annual review to incorporate revisions to align with the 2018 Compliance Plan and current operations
Audit & Oversight	HH.2015: Health Network Claims Processing	▪ Incorporated the OneCare and OneCare Connect programs ▪ Clarified time frames for claims processing and overpayments ▪ Added details to acknowledgement of claims receipt for electronic and paper claims ▪ Added claims audit standards ▪ Updated references	Annual review to incorporate revisions to align with the 2018 Compliance Plan and current operations
Audit & Oversight	HH.2027: Annual Risk Assessment (Delegate)	▪ Clarified that risk analyses and resulting workplans are developed for each delegated First Tier Entity ▪ Added CalOptima Program of All Inclusive Care for the Elderly (PACE) as an applicable program for the policy ▪ Updated references	Annual review to incorporate revisions to align with the 2018 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	HH.3000Δ: Notice of Privacy Practices	▪ Incorporated provisions to ensure compliance with standard threshold languages, language assistance and non-discrimination requirements for Section 1557 of the Affordable Care Act ▪ Added attachments including Notices of Non-Discrimination and language assistance information for all CalOptima programs ▪ Updated references	Annual review to ensure compliance with the 2018 Compliance Plan and incorporate revisions to align with current operations and Section 1557 of the Affordable Care Act
Privacy	HH.3001Δ: Member Access to Designated Record Set	▪ Updated provisions for requests for access to inspect or obtain a copy of the Designated Record Set (DRS) ▪ Clarified the roles and responsibilities of CalOptima departments for the DRS ▪ Updated references	Annual review to ensure compliance with the 2018 Compliance Plan and incorporate revisions to align with current operations
Privacy	HH.3005Δ: Member Request for Accounting of Disclosures	▪ Clarified the disclosures excluded from accounting ▪ Updated references	Annual review to ensure compliance with the 2018 Compliance Plan and incorporate revisions to align with current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	HH.3015Δ: Authorization for Release of Protected Health Information	▪ Revised and clarified language for use and disclosure authorization requests ▪ Updated definitions and references ▪ Attachment A – Authorization for Release of Protected Health Information (PHI): o Clarified language on the form and added mental health and alcohol/drug treatment information will not be released unless specifically authorized ▪ Attachment B – Instruction Sheet: o Clarified who has the authority to act as a member's personal representative ▪ Attachment C – HIPAA Authorization Checklist: o Added statement that the signing of the Authorization for Release of Protected Health Information (PHI) serves no other purpose than authorizing the disclosure of PHI	Annual review to ensure compliance with the 2018 Compliance Plan and incorporate revisions to align with current operations
Regulatory Affairs & Compliance	HH.2021Δ: Exclusion Monitoring	▪ Clarified provisions regarding payment for services provided by excluded individuals and/or entities ▪ Updated provisions regarding initial and monthly exclusion monitoring ▪ Added provision regarding reporting suspended, excluded or terminated providers to the Department of Health Care Services ▪ Updated references	Annual review to incorporate revisions to align with the 2018 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	HH.2022Δ: Record Retention and Access	▪ Updated the list of documents, items and locations CalOptima and First Tier, Downstream and Related Entities are required to retain and make available ▪ Updated provision for the retention requirement of ten (10) years for all CalOptima programs ▪ Clarified regulatory agencies that have the right to inspect ▪ Added provisions regarding the actions a regulatory agency may take upon the possibility of fraud ▪ Updated references	Annual review to incorporate revisions to align with the 2018 Compliance Plan, Medicaid Managed Care Final Rule, and current operations
Regulatory Affairs & Compliance	HH.2028Δ: Code of Conduct	▪ Updated provisions regarding the attestation requirements for First Tier, Downstream and Related Entities ▪ Clarified language on Attachment A: FDR Compliance Attestation for training requirements	Annual review to ensure compliance with the 2018 Compliance Plan and incorporate revisions to align with current operations

Table 2: Office of Compliance Policies and Procedures: Non-substantive Revisions

The following table contains the proposed list of policies without substantive changes for the CalOptima Office of Compliance, by department.

Department	Policy	Summary of Change(s)	Reason for Change(s)
Audit & Oversight	GG.1619: Delegation Oversight	▪ No substantive changes made since the 2016 annual review.	N/A
Audit & Oversight	HH.2025: Health Network Sub-delegation and Sub-contracting	▪ No substantive changes made since the 2016 annual review.	N/A
Audit & Oversight	HH.2026: Claims Delegation and Oversight	▪ No substantive changes made since the 2016 annual review.	N/A
Audit & Oversight	HH.4001Δ: Audit &Oversight Committee	▪ No substantive changes made since the 2016 annual review.	N/A
Audit & Oversight	HH.4002: CalOptima Internal Oversight	▪ No substantive changes made since the 2016 annual review.	N/A

Department	Policy	Summary of Change(s)	Reason for Change(s)
Audit & Oversight	HH.4003: Annual Risk Assessment (Internal)	▪ No substantive changes made since the 2016 annual review.	N/A
Fraud, Waste, and Abuse (FWA)	HH.1105Δ: Fraud, Waste, and Abuse Detection	▪ No substantive changes made since the 2016 annual review.	N/A
FWA	HH1107Δ: Fraud, Waste, and Abuse Investigation and Reporting	▪ No substantive changes made since the 2016 annual review.	N/A
FWA	HH.5000Δ: Provider Overpayment Investigation and Determination	▪ No substantive changes made since the 2016 annual review.	N/A
Privacy	HH.3002Δ: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	▪ No substantive changes made since the 2016 annual review.	N/A
Privacy	HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information	▪ No substantive changes made since the 2016 annual review.	N/A
Privacy	HH.3004Δ: Member Request to Amend Records	▪ No substantive changes made since the 2016 annual review.	N/A
Privacy	HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information	▪ No substantive changes made since the 2016 annual review.	N/A
Privacy	HH.3007Δ: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	▪ No substantive changes made since the 2016 annual review.	N/A
Privacy	HH.3008Δ: Member Right to Request Confidential Communications	▪ No substantive changes made since the 2016 annual review.	N/A
Privacy	HH.3009Δ: Access by Member's Authorized Representative	▪ No substantive changes made since the 2016 annual review.	N/A
Privacy	HH.3010Δ: Protected Health Information Disclosures Required by Law	▪ No substantive changes made since the 2016 annual review.	N/A

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	HH.3011Δ: Use and Disclosure for Treatment, Payment, and Health Care Operations	▪ No substantive changes made since the 2016 annual review.	N/A
Privacy	HH.3014Δ: Use of Electronic Mail with Protected Health Information	▪ No substantive changes made since the 2016 annual review.	N/A
Privacy	HH.3016Δ: Guidelines for Handling Protected Health Information Offsite	▪ No substantive changes made since the 2016 annual review.	N/A
Privacy	HH.3019Δ: De-identification of Protected Health Information	▪ No substantive changes made since the 2016 annual review.	N/A
Privacy	HH.3020Δ: Reporting and Providing a Notice of Security Incidents, Breaches of Unsecured PHI/PI, or other Unauthorized Use of Disclosure of PHI/PI	▪ No substantive changes made since the 2016 annual review.	N/A
Regulatory Affairs & Compliance	HH.2002Δ: Sanctions	▪ No substantive changes made since the 2016 annual review.	N/A
Regulatory Affairs & Compliance	HH.2005Δ: Corrective Action Plan	▪ No substantive changes made since the 2016 annual review.	N/A
Regulatory Affairs & Compliance	HH.2007Δ: Compliance Committee	▪ No substantive changes made since the 2016 annual review.	N/A
Regulatory Affairs & Compliance	HH.2014Δ: Compliance Program	▪ No substantive changes made since the 2016 annual review.	N/A
Regulatory Affairs & Compliance	HH.2018Δ: Compliance and Ethics Hotline	▪ No substantive changes made since the 2016 annual review.	N/A
Regulatory Affairs & Compliance	HH.2019Δ: Reporting Suspended Misconduct or Violation	▪ No substantive changes made since the 2016 annual review.	N/A
Regulatory Affairs & Compliance	HH.2020Δ: Conducting Compliance Investigations	▪ No substantive changes made since the 2016 annual review.	N/A
Regulatory Affairs & Compliance	HH.2023Δ: Compliance Training	▪ No substantive changes made since the 2016 annual review.	N/A

Department	Policy	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	HH.2029Δ: Annual Compliance Program Effectiveness Audit	▪ No substantive changes made since the 2016 annual review.	N/A
Regulatory Affairs & Compliance	HH.3012Δ: Non-Retaliation for Reporting Violations	▪ No substantive changes made since the 2016 annual review.	N/A
Regulatory Affairs & Compliance	MA.9124: CMS Self-Disclosure	▪ No substantive changes made since the 2016 annual review.	N/A

Table 3: Retiring Office of Compliance Policies and Procedures

The following table contains the proposed list of policies and procedures to be retired within the CalOptima Office of Compliance, by department.

Department	Policy	Summary of Change(s)	Reason for Change(s)
Audit & Oversight	MA.7008: Delegation and Oversight of Credentialing and Recredentialing Activities	▪ Requesting retirement of this policy.	Policy was incorporated within GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
Audit & Oversight	MA.9129: Health Network Claims Processing	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2015: Health Network Claims Processing

Policy #: GG.1605
Title: **Delegation and Oversight of Credentialing and Recredentialing Activities**
Department: Office of Compliance
Section: Audit & Oversight ~~(External)~~
CEO Approval: Michael Schrader

Effective Date: 12/95
Last Review Date: 12/07/17~~9/~~
Last Revised Date: ~~1/15~~ ~~9/1/15~~ 12/07/17

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect

I. PURPOSE

~~To establish~~This policy outlines the ~~process~~processes by which CalOptima shall ~~provide and document evidence of oversight of delegated~~ensure Credentialing and Recredentialing activities~~.~~ are performed by Delegated Entities in accordance with quality, state, and federal standards~~.~~.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Corrective Action Plan (CAP)~~	~~A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), or designated representatives. Delegates may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.~~

~~Credentialing~~	~~The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.~~
~~Delegation~~	~~Process by which CalOptima expressly grants, by formal written agreement, to another entity the authority to carry out a function that CalOptima would otherwise be required to perform in order to meet its obligations under its contract with DHCS.~~
~~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~~	~~An 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.~~
~~National Committee for Quality Assurance (NCQA)~~	~~An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.~~
~~Recredentialing~~	~~The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.~~

~~III.~~II. POLICY

A. CalOptima may delegate Credentialing and Recredentialing of a Practitioner to a ~~Health Network, or other delegated Provider~~Delegated Entity, in accordance with this policy.

B. CalOptima shall comply with California rules of Delegation of Quality Improvement Activities, in accordance with Title 28, California Code of Regulations, Section 1300.70(b)(1)(D) and (E~~).~~), including continuous review of the quality of care provided.

C. CalOptima's quality assurance program shall be designed to ensure that:

1. Appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to CalOptima providers, and/or others; and

2. CalOptima does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

~~C.~~D. CalOptima shall comply with Title 42, Code of Federal Regulations, Section 438.230(b), the Medicaid managed care regulation governing delegation and oversight~~.~~, and the Medicare Managed Care Manual, Chapter, 11, Section 110.2.

~~D.~~E. CalOptima shall remain accountable for Credentialing and Recredentialing of its Practitioners, even if CalOptima delegates all or part of these activities.

1. Delegated activities may include, but are not limited to, processing credentialing applications, credentialing decision-making, development of decision-making criteria, credentialing policies and procedures, credentialing verification, credentialing file management, and monitoring of sanctions and exclusions.

~~E.~~F. CalOptima shall be responsible to perform a pre-delegation ~~readiness assessment~~ Readiness Assessment before implementing Delegation. This assessment will include verification that the Delegated Entity has devoted sufficient resources and appropriately qualified staff to perform the functions. The following shall be mutually agreed upon between CalOptima and the delegated party:

1. A written Delegation Acknowledgment and Acceptance Agreement Document (hereafter Delegation Agreement) describing all ~~of~~ the delegated Credentialing activities; and

2. CalOptima shall retain the right to approve, suspend, and terminate individual ~~Practitioners, Providers~~Ppractitioners, providers, and sites in situations where CalOptima has delegated decision making, as addressed in the ~~Delegation Agreement.~~ delegation agreement. CalOptima shall not sub-delegate Peer Review Body functions and the determination of a Practitioner's participation in the CalOptima program.

3. CalOptima shall monitor the performance of a delegated entity on an ongoing basis.

~~F.~~G. On an annual basis, CalOptima shall perform an audit of Credentialing ~~file audits against National Committee for Quality Assurance (NCQA)~~written policies and ~~contractual standards for each year that the delegation, is in effect. The annual audit shall be based on the responsibilities stated in the Delegation Agreement and performance of delegated activities,~~procedures as well as ~~the appropriate NCQA and contractual standards.~~ a review of Credentialing files.

~~G.~~H. On a monthly basis, CalOptima shall evaluate required reports as agreed upon in the Delegation Agreement~~, unless specified otherwise.~~. CalOptima shall conduct a monthly Credentialing and Recredentialing file review ~~for each line of business~~, unless otherwise specified.

~~H.~~I. CalOptima shall identify and follow-up on opportunities for improvement, if applicable.

~~I.~~ CalOptima shall require a ~~delegated Health Network~~Delegated Entity to respond to a Corrective Action Plan (CAP), based on any deficiency or area of non-compliance determined during the ~~Pre-Delegation~~pre-delegation Readiness Assessment, ~~Monthly File Review~~monthly file review, or ~~Annual Audit~~annual audit.

J.

~~IV.~~III. PROCEDURE

A. ~~The~~Subject to CalOptima's approval of the delegated activities, the written Delegation Agreement shall include the following:

1. Mutual agreement ~~on the Delegation document,~~ demonstrated by signatures from both CalOptima and the ~~delegated Health Network or other delegated Provider~~Delegated Entity, and a description of:

    a. Delegated activities;

    b. CalOptima and the ~~delegated Health Network or other delegated Provider~~Delegated Entity responsibilities, which at a minimum include:

        i. Acceptance of applications, reapplications, and attestations;

        ii. Collection of all data elements from NCQA ~~sources, in accordance with CalOptima Policy GG.1609: Credentialing and Recredentialing;~~or other appropriate sources, in accordance with CalOptima Policies;

        iii. Collection and evaluation of ongoing monitoring information; and

        iv. Decision-making in respect to oversight of Credentialing activities.

    c. Reporting responsibilities, which shall indicate a minimum of monthly reporting, unless specified otherwise. The reporting ~~-~~responsibilities shall be noted on the ~~Credentialing Monthly Report Log~~Timely and Appropriate Submissions Grid, and include:

        i. A list of Credentialed ~~and,~~ Recredentialed, and Terminated Practitioners~~,~~ submitted monthly to ~~CalOptima~~;

    d. The process by which CalOptima evaluates the ~~delegated Health Network or other delegated Provider~~Delegated Entity's performance, which includes:

        i. Pre-Delegation Readiness Assessment;

        ii. Monthly ~~File Review~~file review;

        iii. Annual ~~Audit~~audit; and

        iv. Reporting.

    e. Remedies available to CalOptima if the ~~delegated Health Network or other delegated Provider~~Delegated Entity does not fulfill its obligations, including revocation of the Delegation Agreement, and Sanctions as referenced in CalOptima Policy HH.~~2002~~2002Δ: Sanctions;

    f. CalOptima's right to approve, suspend and terminate individual ~~Practitioners, Providers~~Ppractitioners, providers, and sites in situations where CalOptima has delegated decision~~-~~-making; and

g. CalOptima's right to reject a Practitioner upon reason that the Practitioner has failed to meet the Credentialing or Recredentialing requirements, as outlined in the Delegation Agreement and CalOptima Policy GG.1616: Fair Hearing Plan for Practitioners.Policies.

B. Pre-Delegation Readiness Assessment

1. CalOptima shall conduct a pre-delegation readiness assessmentReadiness Assessment of a Health Network or other delegated ProviderDelegated Entity to determine the Health Network's, or other delegated Provider'sDelegated Entity's ability to implement delegated Credentialing and Recredentialing activities prior to the agreementbefore entering into and implementation ofimplementing a Delegation Agreement. .

2. The pre-delegation readiness assessmentReadiness Assessment shall consist of a comprehensive desk review and on-site evaluation, utilizing the Delegation Oversight Audit Tooldelegation oversight audit tool, which will evaluate a Health Network's or other delegated Provider'sDelegated Entity's capacity to provide all delegated functions. Consideration will be given to utilizing a current Industry Collaboration Effort (ICE) Shared Credentialing Audit, if relevant CalOptima programs are included. Additional documentation may need to be provided to complete the audit. The evaluation shall include:

   a. Written review of the Health Network's or other delegated Provider'sDelegated Entity's understanding of applicable standards;

   b. Delegated tasks;

   c. Review of policypolicies and procedures;

   d. Staffing capabilities;

   e. Performance records;

   f. Review of Credentialing system; and

   g. Credentialing and Recredentialing File review.

3. Upon completion of the pre-delegation readiness assessmentReadiness Assessment, CalOptima's Director of Audit & Oversight shall report the pre-delegation readiness assessmentReadiness Assessment results to the Delegation Audit &Oversight Committee (DOC) MeetingAOC) meeting.

4. The DOCAOC shall determine if the Health Network or other delegated ProviderDelegated Entity meets CalOptima's criteria for Delegation of Credentialing and Recredentialing activities based on the results of the Health Network's or other delegated Provider's pre-delegation readiness assessmentReadiness Assessment.

a. If the ~~DOC~~AOC determines that a ~~Health Network or other delegated Provider~~Delegated Entity does not meet CalOptima's criteria for Delegation of Credentialing and Recredentialing activities, CalOptima may reassess such ~~Health Network or other delegated Provider~~Delegated Entity no earlier than three (3) months after the initial pre-delegation ~~readiness assessment.~~ Readiness Assessment.

C. ~~Health Network or other delegated Provider~~Delegated Entity Responsibilities

1. A ~~delegated Health Network or other delegated Provider~~Delegated Entity shall:

a. Develop and implement processes, in accordance with this policy, for the Credentialing and Recredentialing of Practitioners with whom it contracts or employs;

b. Develop policies and procedures that:

i. Are consistent with this policy, and specify:

a) Types of Practitioners covered;

b) Criteria for Credentialing and Recredentialing; and

c) Verification sources used; and

ii. Address the following:

a) The process to ~~sub~~ delegate Credentialing or Recredentialing activities;

b) The process used to ensure that Credentialing and Recredentialing are conducted in a non-discriminatory manner;

c) The process for written notification to a Practitioner of any information obtained during the ~~Health Network's or other delegated Provider's~~Delegated Entity's Credentialing process that varies substantially from the information provided ~~to the Health Network or other delegated provider~~ by the Practitioner;

d) The process to ensure that Practitioners are notified of the Credentialing or Recredentialing decision within sixty (60) calendar days after the ~~Peer Review Body's (PRB)~~ decision~~;~~.

e) The medical director or other designated physician's direct responsibility and participation in the Credentialing program;

f) The process used to ensure the ~~Confidentiality~~confidentiality of all information obtained in the Credentialing process, except as otherwise provided by law; and

g) The process for making Credentialing and Recredentialing decisions; and

iii. Include the Practitioner's right to:

a) Review information submitted to support his or her Credentialing application;

b) Correct erroneous information;

c) Request information on the status of his or her Credentialing or Recredentialing application; and

d) Receive notification of these rights; and

iv. Address ongoing monitoring of:

a) Medicare and Medicaid Sanctions;

b) State ~~Sanctions~~sanctions or limitations on licensure; and

c) Complaints~~.~~ and grievances.

c. Develop policies and procedures to verify the participation status of the ~~Health Network's, or other delegated Provider's~~Delegated Entity's agents to ensure that they shall:

i. Immediately disclose to CalOptima's Audit and Oversight Department any pending investigation involving, or any determination of, suspension, exclusion, or debarment by the ~~Health Network or other delegated Provider, or Health Network or other delegated Provider~~Delegated Entity or its agents, occurring or discovered during the term of the Contract for Health Care Services; and

ii. Take immediate action to remove any ~~Health Network or other delegated Provider~~Delegated Entity agent that does not meet participation status requirements from furnishing items or services related to the ~~Contract for~~ Health ~~Care Services~~Network Service Agreement (whether medical or administrative) to Members.

d. Designate dedicated staff responsible for the timely Credentialing and Recredentialing of all Practitioners; and

e. Credential and ~~Recredential~~recredential Practitioners, in accordance with CalOptima ~~Policy GG.1609: Credentialing and Recredentialing~~Policies.

D. Sub-~~delegation~~Delegation

~~1.~~ ~~CalOptima~~A Delegated Entity shall not ~~sub-delegate PRB functions and the determination of a Provider's participation in the CalOptima program.~~

2.1. A delegated Health Network or other delegated Provider shall not sub- delegate any Credentialing or Recredentialing activity without prior written approval from CalOptima.

3.2. A delegated Health Network or other delegated Provider may only sub-delegateIf a Delegated Entity delegates to a credentialing verification organization (CVO)), CalOptima requires that isthe CVO be certified by NCQA pursuant to the Contract for Health Care Services.. The Health Network, or other delegated ProviderDelegated Entity shall retain ultimate responsibility for any sub- delegated activities.

4.3. Prior to sub- delegating Credentialing activities to a CVO, the Health Network or other delegated Provider, Delegated Entity shall evaluate the CVO'spotential Sub-Delegate's capacity to perform such activities, according to CalOptima Credentialing and Recredentialing standards.

5.4. The sub- delegated activities shall be described in a written agreementDelegation Agreement with the CVOSub-Delegate. The agreement between the Health Network, or other delegated ProviderDelegated Entity and a CVOSub-Delegate shall include all of the following:

a. The responsibilities of each party;

b. The sub- delegated activities;

c. The process by which CalOptima, a Health Network or other delegated ProviderDelegated Entity shall evaluate the CVO'sSub-Delegate's performance;

d. The remedies, including revocation of sub- delegation, available to CalOptima or the Health Network or other delegated ProviderDelegated Entity if the CVOSub-Delegate does not fulfill its obligations;

e. A process for regular reports by the CVOSub-Delegate to CalOptima or the Health Network or other delegated ProviderDelegated Entity;

f. The Delegated Entity shall provide ongoing monitoring of the Sub-Delegate's activities under the agreement;

g. Both CalOptima and the Delegated Entity's Peer Review Body shall retain the right to approve, terminate or suspend individual practitioners, providers or sites based upon quality issues;

f.h. Agreement as to the exchange of information between the Health Network or other delegated ProviderDelegated Entity and the CVOSub-Delegate, including a definition of peer review or confidential information, and a process for sharing information with each other and with third parties;

g.i. A process for handling Protected Health Information (PHI), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) as amended; and

~~h.~~j. A monitoring schedule.

~~6.~~5. A ~~Health Network or other delegated Provider~~Delegated Entity shall be responsible for providing oversight for all ~~sub-~~delegated Credentialing activities.

~~7.~~6. On an annual basis, ~~the Health Network, or other delegated Provider~~Delegated Entity shall evaluate the ~~CVO's~~Sub-Delegate's Credentialing process. The evaluation shall ensure that the ~~sub-~~delegated activities are conducted~~,~~ in accordance with CalOptima's Credentialing standards.

~~8.~~7. The ~~Health Network or other delegated Provider~~Delegated Entity shall submit to CalOptima an annual report documenting the ~~HNs or other delegated provider's~~Delegated Entity's evaluation process of the ~~sub-~~delegated function.

~~9. The Health Network's or other delegated Provider's PRB shall retain the right to approve new Practitioners or sites, and to terminate or suspend individual Practitioners based upon quality issues.~~

~~10.~~8. CalOptima shall monitor the ~~Health Network's or other delegated Provider's~~Delegated Entity's oversight process of the ~~CVO~~Sub-Delegate through CalOptima's annual oversight of the ~~Health Network's or other delegated Provider's~~Delegated Entity's Credentialing and Recredentialing process.

E. Annual Audit

1. On an annual basis, CalOptima shall perform ~~a substantive evaluation~~ an audit of ~~all Health Network or other Providers~~written policies and procedures as well as a review of Credentialing files to ensure compliance with ~~whom CalOptima has delegated activities against~~ the National Committee for Quality Assurance (NCQA) and contractual standards~~,~~ for each year that the delegation is in ~~accordance with this policy.~~effect. The annual audit shall be based on the ~~mutually agreed upon~~ responsibilities stated in the Delegation Agreement and performance of delegated activities, as well as the appropriate NCQA and contractual standards. This audit may be performed on-site or via desktop review. Consideration will be given to utilizing a current Industry Collaboration Effort (ICE) Shared Credentialing Audit, if relevant CalOptima programs are included. Additional documentation may need to be provided to complete the audit.

2. The annual audit shall include the review of policies and procedures utilizing the ~~Delegation Oversight Annual Audit Tool~~delegation oversight annual audit tool. This audit will include, but not be limited to:

   a. A review of ~~Health Network or other delegated Providers PRB~~Delegated Entity's Peer Review Body meeting minutes, which shall be conducted for Credentialing and Recredentialing activities;

b. A review to confirm the ~~Health Network's or other delegated Provider's~~Delegated Entity's reporting procedure to CalOptima when there is action taken against a ~~Practitioner~~practitioner that relates to professional behavior or clinical competence, and suspensions, terminations, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the ~~Health Network's or Provider's PRB~~Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG~~)).~~), or the National Practitioner Data Bank (NPDB).)

3. An annual file review is also conducted utilizing the Credentialing and Recredentialing ~~File Review Tool~~file review tool:

   a. CalOptima shall apply the 8/30 methodology when conducting the ~~Annual File Review~~annual file review. CalOptima will select a random sample of thirty (30) Credentialing and thirty (30) Recredentialing files, and will provide the organization with the file selection.

      i. Eight (8) of each file type will be randomly chosen for the initial review. Credentialing requirements applicable to both file types are scored for all files. CalOptima shall review files until it has sufficient results to score based on the 8/30 methodology.

   b. If the requirement applies only to initial Credentialing files (e.g., work history) or to Recredentialing files (e.g., Recredentialing cycle length), the requirement is scored 'Not Applicable' for the file type that does not apply. CalOptima shall score only applicable files until it has sufficient results to score based on its 8/30 methodology.

      i. If fewer than thirty (30) Practitioners were Credentialed or Recredentialed within the look back period, CalOptima shall audit the universe of files rather than a sample.

   c. CalOptima shall review documentation of substantive evaluation and action plans, if needed.

   d. If the ~~Health Network or other delegated Provider~~Delegated Entity does not have any files for Credentialing or Recredentialing between audit cycles, CalOptima will not perform an annual audit, but instead shall require the ~~Health Network or other delegated Provider~~Delegated Entity to meet all other ~~Delegation~~delegation oversight requirements, and provide documentation that the ~~Health Network or other delegated Provider~~Delegated Entity did not Credential or Recredential Practitioners between audit cycles.

4. Based on the results of the annual audit, CalOptima may take the following actions:

   a. Require a ~~Health Network or other delegated Provider~~Delegated Entity to respond to and submit a CAP addressing all areas of deficiency as determined by CalOptima in accordance with CalOptima Policy HH.~~2005~~2005Δ: Corrective Action Plan;

b. Audit the ~~Health Network's or other delegated Provider's~~Delegated Entity's implementation and completion of an approved CAP, and any performance area(s) addressed in the CAP;

c. Impose Sanctions against a ~~Health Network or other delegated Provider~~Delegated Entity, in accordance with CalOptima Policy HH.~~2002~~2002Δ: Sanctions;

d. Initiate the de-delegation process in accordance with Section ~~III~~IIIV~~.~~.F of this policy.

5. CalOptima staff shall report findings from oversight reviews and CAPs to the ~~DOC,~~AOC with recommendations for follow-up activities.

F. De-~~delegation~~Delegation

1. The Audit & Oversight Credentialing ~~auditor~~Auditor shall review CAPs that do not meet the compliance threshold or are classified as 'delinquent,' and shall make appropriate recommendations to the ~~DOC~~AOC.

2. The ~~DOC~~AOC shall review a ~~Health Network's, or other delegated Provider's~~Delegated Entity's Delegation status based on the CAP timeline and level of achievement.

3. If a ~~Health Network or other delegated Provider~~Delegated Entity fails to achieve compliance within the timeframes set forth in the CAP, the ~~DOC~~AOC may recommend de-delegation of Credentialing and Recredentialing.

4. If the ~~DOC approves~~ AOC recommends de-delegation of Credentialing and Recredentialing activities from the ~~Health Network, or other delegated Provider~~Delegated Entity, and Compliance Committee approves the recommendation, CalOptima shall:

a. Provide the ~~Health Network or other delegated Provider~~Delegated Entity with thirty (30) calendar days written notice of CalOptima's intent to de-delegate;

b. Inform ~~Providers~~Practitioners of the de-delegation and instructions for continued services;

c. Adjust the ~~Health Network's or other delegated Provider's~~Delegated Entity's payments as appropriate to the de-delegated status of Credentialing and Re-credentialing activities; and

d. Prepare appropriate CalOptima departments to ~~provide~~perform the de-delegated Credentialing and Recredentialing activities~~.~~; and

e. ~~A Health Network or other delegated Provider~~CalOptima shall inform the Delegated Entity and Practitioners of their right to file an Appeal.

5. A Delegated Entity shall cooperate with CalOptima to ensure smooth transition and continuous care for Members during the de-delegation transition period.

6. CalOptima ~~shall~~may re-evaluate a ~~Health Network's, or other delegated Provider's~~Delegated Entity's ability to perform delegated Credentialing and Recredentialing activities no ~~less~~sooner than twelve (12) months after de-delegation.

   a. CalOptima shall utilize the pre-delegation ~~readiness assessment~~Readiness Assessment process, as described in Section ~~IV~~III.B of this policy.

   b. CalOptima shall delegate Credentialing and Recredentialing activities to ~~the Health Network, or other delegated Provider~~Delegated Entity based on the pre-delegation ~~readiness assessment~~Readiness Assessment results.

   c. The Director of Audit & Oversight shall present the re-audit pre-delegation ~~readiness assessment~~Readiness Assessment to the ~~DOC~~AOC.

   d. If the ~~DOC approves~~ AOC recommends approval of Delegation of Credentialing and Recredentialing activities to the ~~Health Network, or other delegated Provider~~Delegated Entity, and the Compliance Committee approves the recommendation, CalOptima shall re-delegate such activities, and adjust the ~~Health Network's, or other delegated Provider's~~Delegated Entity's payment accordingly.

   e. If the ~~DOC denies~~AOC recommends denial of re-delegation of Credentialing and Recredentialing activities to the ~~Health Network, or other delegated Provider~~Delegated Entity, it may also recommend additional Sanctions on the ~~Health Network, , or other delegated Provider~~Delegated Entity, up to and including termination of the Contract for Health Care Services, to the Compliance Committee for final action.

7. CalOptima shall inform the ~~Health Network, or other delegated Provider and Practitioner's~~Delegated Entity and Practitioners of their right to file an Appeal.

H. ~~-~~Exchange of Information

1. CalOptima may, at its discretion, share ~~with another Health Network, or other delegated Provider,~~ copies of a report received from a ~~Health Network, or other delegated Provider~~Delegated Entity regarding an adverse action, if CalOptima deems that such report may protect the medical care of a Member.

   a. Such reports may include, but are not limited to, action taken against a Practitioner that relates to professional behavior or clinical competence, suspensions, terminations, legal actions, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG) or the National Practitioner Data Bank (NPDB)~~.~~).

   ~~a.~~b. The provision of any such report to another ~~Health Network or other delegated Provider~~Delegated Entity shall not relieve the ~~Health Network, or other delegated Provider,~~

~~or any other entity,~~Delegated Entity of an independent duty to comply with Credentialing procedures or to query or file a report with state or federal regulatory agencies.

2. CalOptima retains the right to review all components of a ~~Health Network, or other delegated Provider's~~Delegated Entity's file.

I. ~~I.~~ Monitoring

1. CalOptima shall monitor a ~~delegated Health Network's or other delegated Provider's~~Delegated Entity's Credentialing and Recredentialing activities through reports, monthly file reviews, and continuous improvement activities.

   a. Monthly Credentialing Universe

      i. The Monthly Credentialing Universe is due to CalOptima on the second (2nd) day of every month.

         a) Universes ~~for each line of business~~ must be submitted via FTP server to the 'HN_Reporting' folder utilizing the instructed naming conventions. Effective January 1, 2016, a single universe template will be utilized for reporting all contracted lines of business.

   b. Monthly File Review

      i. On a monthly basis, CalOptima will review Credentialing and Recredentialing files for each delegate. Delegates that are NCQA-Certified or Accredited are exempt from the Monthly File Review, but are still required to submit Monthly Credentialing Universes.

         a) The CalOptima auditor will select the following file types at random from the Monthly Credentialing Universe submitted:

            1. Eight (8) Credentialing Files; and

            2. Eight (8) Recredentialing Files.

      ii. The CalOptima auditor will notify the ~~Health Network or other delegated Provider~~Delegated Entity via email of the file selection no later than the fourth (4th) of every month.

      iii. The ~~Health Network or other delegated Provider~~Delegated Entity shall submit the selected Credentialing and ~~Recredentailing~~Recredentialing files to CalOptima on the ~~eighth~~tenth (10th) of every month.

         a) Credentialing and ~~Re-credentialing~~Recredentialing files ~~for each line of business~~ must be submitted via FTP server into the 'HN_Reporting' folder utilizing the instructed naming conventions.

~~2. A delegated Health Network or other delegated Provider~~2. A Delegated Entity shall submit reports to CalOptima on a periodic basis, as specified by CalOptima, including, but not limited to, those reports based on the mutually agreed-upon Delegation ~~document:~~ Agreement:

a. Reports shall include, but are not limited to:

i. Monthly Credentialing and Recredentialing reports;

ii. A ~~lists~~list of all active Practitioners ~~with current licensure, Credentialing and~~on an annual basis;
~~Recredentialing dates, Drug Enforcement Administration (DEA) certification, malpractice information, and other specified information;~~

iii. Verification of Board Certification for Practitioners who claim Board Certification status; and

iv. Annual reports of any ~~sub-delegated entity's~~Sub-Delegate's performance, if CalOptima approved such sub-delegation.

b. ~~A delegated Health Network or other delegated Provider~~A Delegated Entity shall submit such reports to CalOptima in accordance with the Delegation Agreement

i. CalOptima shall require a ~~Health Network or delegated Provider~~Delegated Entity:

a) To notify CalOptima immediately of any investigation by a regulatory or licensing agency of a Practitioner that relates to professional behavior or clinical competence, and suspensions, terminations, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the ~~Health Network's or delegated provider's PRB~~Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG~~)).~~)) or the National Practitioner Data Bank (NPDB)~~.~~).

b) To provide CalOptima copies of any California Business and Professions Code, Section 805 reports, or National Practitioner Data Bank reports, at the time the report is filed.

~~V.~~IV. ATTACHMENTS

A. Monthly Credentialing Universe

~~VI.~~V. REFERENCES

~~A. Contract for Health Care Services~~
~~B.~~A. ~~2015~~ 2016-2017 NCQA Standards for the Accreditation

B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal Health Network Service Agreement
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal Health Network Service Agreement~~
~~C.~~ California Business and Professions Code, Section ~~805~~
F. ~~CalOptima~~805
~~D.~~G. CalOptima Policy AA.1000: Glossary of Terms
H. CalOptima ~~Global~~Policy MA.1001: Glossary of Terms
I. CalOptima Policy CMC.1001 Glossary of Terms
~~E.~~J. CalOptima Policy GG.~~1609~~1650Δ: Credentialing and Recredentialing
~~F. CalOptima Policy GG.1605: Delegation Oversight of Credentialing and Recredentialing Activities~~
~~G. CalOptima Policy GG.1616: Fair Hearing Plan for Practitioners~~
K. CalOptima Policy HH.~~2005~~2002Δ: Sanctions
~~H.~~L. CalOptima Policy HH.2005Δ: Corrective Action Plan
~~I. CalOptima Policy HH.2002: Sanctions~~

~~J.~~ Medicare Managed Care Manual, Chapter 11, Section 110.2Title 28, California Code of Regulations, Section 1300.70(b)(1)(D) and (E)
M.
N. Title 42, Code of Federal Regulations, Section 438.230(b)

~~VII.~~VI. REGULATORY AGENCY APPROVALS

A. ~~6~~06/29/15: ~~—~~ Department of Health Care Services

~~VIII.~~VII. BOARD ~~ACTION~~ACTIONS

~~Not Applicable~~
~~None to Date~~12/07/17: Regular Meeting of the CalOptima Board of Directors
A.

~~IX.~~VIII. REVIEW/ REVISION HISTORY

Version	~~Version~~ Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	12/1995	GG.1605	Credentialing, Monitoring Health Network Compliance	Medi-Cal

Version	~~Version~~ Date	Policy Number	Policy Title	Line(s) of Business
~~Revision Date 1~~Revised	08/1998	GG.1605	Credentialing, Monitoring Health Network Compliance	Medi-Cal
~~Revision Date 2~~Revised	02/2001	GG.1605	Delegation and Oversight of Credentialing and Recredentialing Activities	Medi-Cal
~~Revision Date 3~~Revised	07/01/2007	GG.1605	Delegation and Oversight of Credentialing and Recredentialing Activities	Medi-Cal
~~Revision Date 4~~Revised	06/01/2014	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal
~~Revision Date 5~~Revised	09/01/2015	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	12/07/2017	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consists of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance Officer; and Executive Director of Human Resources.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. First Tier, Downstream and Related Entities and/or CalOptima departments may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Delegated Entity	An entity, such as a Health Network, Pharmacy Benefits Manager (PBM), Managed Behavioral Health Organization (MBHO) or other entity to whom CalOptima delegates Member care or administrative responsibilities. Additionally, any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services. Functions may be delegated by written contract only and only as permitted by CMS and/or State governmental agencies, as applicable to the specific program.
Delegation	A legal assignment to another party of the responsibility for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements and obligations pertaining to the delegated functions.

Term	**Definition**
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima program.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations("HMOs").
Member	A beneficiary who is enrolled in a CalOptima program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Recredentialing	The process by which the qualifications of Practitioners are verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Practitioner	An individual who provides covered services pursuant to a state license, including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist.
Readiness Assessment	An assessment conducted by a Review Team prior to the effective date of a Health Network's or other contracted entity's Contract with CalOptima of a Health Network or contracted entity's compliance with all or a specified number of operational functional areas as determined by CalOptima.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Term	Definition
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier, Downstream or Related Entity's(FDR) or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Sub-Delegate	An entity that has entered into a written agreement with a Health Network or other delegated Provider to perform certain operational functions that would otherwise be required to be performed by CalOptima, the Health Network or other delegated Provider, in order to meet contractual and/or regulatory obligations. Examples of a Sub-Delegate may include, but are not limited to, a management services organization (MSO) or a credentials verification organization (CVO).

Policy #:	GG.1605
Title:	**Delegation and Oversight of Credentialing and Recredentialing Activities**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	Michael Schrader
Effective Date:	12/95
Last Review Date:	12/07/17
Last Revised Date:	12/07/17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy outlines the processes by which CalOptima shall ensure Credentialing and Recredentialing activities are performed by Delegated Entities in accordance with quality, state, and federal standards.

II. POLICY

A. CalOptima may delegate Credentialing and Recredentialing of a Practitioner to a Delegated Entity, in accordance with this policy.

B. CalOptima shall comply with California rules of Delegation of Quality Improvement Activities, in accordance with Title 28, California Code of Regulations, Section 1300.70(b)(1)(D) and (E), including continuous review of the quality of care provided.

C. CalOptima's quality assurance program shall be designed to ensure that:

1. Appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to CalOptima providers, and/or others; and

2. CalOptima does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

D. CalOptima shall comply with Title 42, Code of Federal Regulations, Section 438.230(b), the Medicaid managed care regulation governing delegation and oversight, and the Medicare Managed Care Manual, Chapter, 11, Section 110.2.

E. CalOptima shall remain accountable for Credentialing and Recredentialing of its Practitioners, even if CalOptima delegates all or part of these activities.

1. Delegated activities may include, but are not limited to, processing credentialing applications, credentialing decision-making, development of decision-making criteria, credentialing policies

and procedures, credentialing verification, credentialing file management, and monitoring of sanctions and exclusions.

F. CalOptima shall be responsible to perform a pre-delegation Readiness Assessment before implementing Delegation. This assessment will include verification that the Delegated Entity has devoted sufficient resources and appropriately qualified staff to perform the functions. The following shall be mutually agreed upon between CalOptima and the delegated party:

1. A written Delegation Acknowledgment and Acceptance Agreement Document (hereafter Delegation Agreement) describing all the delegated Credentialing activities; and

2. CalOptima shall retain the right to approve, suspend, and terminate individual Practitioners, providers, and sites in situations where CalOptima has delegated decision making, as addressed in the delegation agreement. CalOptima shall not sub-delegate Peer Review Body functions and the determination of a Practitioner's participation in the CalOptima program.

3. CalOptima shall monitor the performance of a delegated entity on an ongoing basis.

G. On an annual basis, CalOptima shall perform an audit of Credentialing written policies and procedures as well as a review of Credentialing files.

H. On a monthly basis, CalOptima shall evaluate required reports as agreed upon in the Delegation Agreement. CalOptima shall conduct a monthly Credentialing and Recredentialing file review, unless otherwise specified.

I. CalOptima shall identify and follow-up on opportunities for improvement, if applicable.

J. CalOptima shall require a Delegated Entity to respond to a Corrective Action Plan (CAP), based on any deficiency or area of non-compliance determined during the pre-delegation Readiness Assessment, monthly file review, or annual audit.

III. PROCEDURE

A. Subject to CalOptima's approval of the delegated activities, the written Delegation Agreement shall include the following:

1. Mutual agreement demonstrated by signatures from both CalOptima and the Delegated Entity, and a description of:

a. Delegated activities;

b. CalOptima and the Delegated Entity responsibilities, which at a minimum include:

i. Acceptance of applications, reapplications, and attestations;

ii. Collection of all data elements from NCQA or other appropriate sources, in accordance with CalOptima Policies;

iii. Collection and evaluation of ongoing monitoring information; and

iv. Decision-making in respect to oversight of Credentialing activities.

c. Reporting responsibilities, which shall indicate a minimum of monthly reporting, unless specified otherwise. The reporting responsibilities shall be noted on the Timely and Appropriate Submissions Grid, and include:

i. A list of Credentialed, Recredentialed, and Terminated Practitioners submitted monthly to CalOptima;

d. The process by which CalOptima evaluates the Delegated Entity's performance, which includes:

i. Pre-Delegation Readiness Assessment;

ii. Monthly file review;

iii. Annual audit; and

iv. Reporting.

e. Remedies available to CalOptima if the Delegated Entity does not fulfill its obligations, including revocation of the Delegation Agreement, and Sanctions as referenced in CalOptima Policy HH.2002Δ: Sanctions;

f. CalOptima's right to approve, suspend and terminate individual Practitioners, providers, and sites in situations where CalOptima has delegated decision-making; and

g. CalOptima's right to reject a Practitioner upon reason that the Practitioner has failed to meet the Credentialing or Recredentialing requirements, as outlined in the Delegation Agreement and CalOptima Policies.

B. Pre-Delegation Readiness Assessment

1. CalOptima shall conduct a pre-delegation Readiness Assessment of a Delegated Entity to determine the Delegated Entity's ability to implement delegated Credentialing and Recredentialing activities before entering into and implementing a Delegation Agreement.

2. The pre-delegation Readiness Assessment shall consist of a comprehensive desk review and on-site evaluation, utilizing the delegation oversight audit tool, which will evaluate a Delegated Entity's capacity to provide all delegated functions. Consideration will be given to utilizing a current Industry Collaboration Effort (ICE) Shared Credentialing Audit, if relevant CalOptima programs are included. Additional documentation may need to be provided to complete the audit. The evaluation shall include:

a. Written review of the Delegated Entity's understanding of applicable standards;

b. Delegated tasks;

c. Review of policies and procedures;

d. Staffing capabilities;

e. Performance records;

f. Review of Credentialing system; and

g. Credentialing and Recredentialing File review.

3. Upon completion of the pre-delegation Readiness Assessment, CalOptima's Director of Audit & Oversight shall report the pre-delegation Readiness Assessment results to the Audit &Oversight Committee (AOC) meeting.

4. The AOC shall determine if the Delegated Entity meets CalOptima's criteria for Delegation of Credentialing and Recredentialing activities based on the results of the pre-delegation Readiness Assessment.

a. If the AOC determines that a Delegated Entity does not meet CalOptima's criteria for Delegation of Credentialing and Recredentialing activities, CalOptima may reassess such Delegated Entity no earlier than three (3) months after the initial pre-delegation Readiness Assessment.

C. Delegated Entity Responsibilities

1. A Delegated Entity shall:

a. Develop and implement processes, in accordance with this policy, for the Credentialing and Recredentialing of Practitioners with whom it contracts or employs;

b. Develop policies and procedures that:

i. Are consistent with this policy, and specify:

a) Types of Practitioners covered;

b) Criteria for Credentialing and Recredentialing; and

c) Verification sources used; and

ii. Address the following:

a) The process to delegate Credentialing or Recredentialing activities;

b) The process used to ensure that Credentialing and Recredentialing are conducted in a non-discriminatory manner;

c) The process for written notification to a Practitioner of any information obtained during the Delegated Entity's Credentialing process that varies substantially from the information provided by the Practitioner;

d) The process to ensure that Practitioners are notified of the Credentialing or Recredentialing decision within sixty (60) calendar days after the decision.

e) The medical director or other designated physician's direct responsibility and participation in the Credentialing program;

f) The process used to ensure the confidentiality of all information obtained in the Credentialing process, except as otherwise provided by law; and

g) The process for making Credentialing and Recredentialing decisions; and

iii. Include the Practitioner's right to:

a) Review information submitted to support his or her Credentialing application;

b) Correct erroneous information;

c) Request information on the status of his or her Credentialing or Recredentialing application; and

d) Receive notification of these rights; and

iv. Address ongoing monitoring of:

a) Medicare and Medicaid Sanctions;

b) State sanctions or limitations on licensure; and

c) Complaints and grievances.

c. Develop policies and procedures to verify the participation status of the Delegated Entity's agents to ensure that they shall:

i. Immediately disclose to CalOptima's Audit and Oversight Department any pending investigation involving, or any determination of, suspension, exclusion, or debarment by the Delegated Entity or its agents, occurring or discovered during the term of the Contract for Health Care Services; and

ii. Take immediate action to remove any Delegated Entity agent that does not meet participation status requirements from furnishing items or services related to the Health Network Service Agreement (whether medical or administrative) to Members.

d. Designate dedicated staff responsible for the timely Credentialing and Recredentialing of all Practitioners; and

e. Credential and recredential Practitioners, in accordance with CalOptima Policies.

D. Sub-Delegation

1. A Delegated Entity shall not delegate any Credentialing or Recredentialing activity without prior written approval from CalOptima.

2. If a Delegated Entity delegates to a credentialing verification organization (CVO), CalOptima requires that the CVO be certified by NCQA. The Delegated Entity shall retain ultimate responsibility for any delegated activities.

3. Prior to delegating Credentialing activities, Delegated Entity shall evaluate the potential Sub-Delegate's capacity to perform such activities, according to CalOptima Credentialing and Recredentialing standards.

4. The delegated activities shall be described in a written Delegation Agreement with the Sub-Delegate. The agreement between the Delegated Entity and a Sub-Delegate shall include all of the following:

   a. The responsibilities of each party;

   b. The delegated activities;

   c. The process by which a Delegated Entity shall evaluate the Sub-Delegate's performance;

   d. The remedies, including revocation of delegation, available to the Delegated Entity if the Sub-Delegate does not fulfill its obligations;

   e. A process for regular reports by the Sub-Delegate to the Delegated Entity;

   f. The Delegated Entity shall provide ongoing monitoring of the Sub-Delegate’s activities under the agreement;

   g. Both CalOptima and the Delegated Entity’s Peer Review Body shall retain the right to approve, terminate or suspend individual practitioners, providers or sites based upon quality issues;

   h. Agreement as to the exchange of information between the Delegated Entity and the Sub-Delegate, including a definition of peer review or confidential information, and a process for sharing information with each other and with third parties;

   i. A process for handling Protected Health Information (PHI), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) as amended; and

   j. A monitoring schedule.

5. A Delegated Entity shall be responsible for providing oversight for all delegated Credentialing activities.

6. On an annual basis, Delegated Entity shall evaluate the Sub-Delegate's Credentialing process. The evaluation shall ensure that the delegated activities are conducted in accordance with CalOptima's Credentialing standards.

7. The Delegated Entity shall submit to CalOptima an annual report documenting the Delegated Entity's evaluation process of the delegated function.

8. CalOptima shall monitor the Delegated Entity's oversight process of the Sub-Delegate through CalOptima's annual oversight of the Delegated Entity's Credentialing and Recredentialing process.

E. Annual Audit

1. On an annual basis, CalOptima shall perform an audit of written policies and procedures as well as a review of Credentialing files to ensure compliance with the National Committee for Quality Assurance (NCQA) and contractual standards for each year that the delegation is in effect. The annual audit shall be based on the responsibilities stated in the Delegation Agreement and performance of delegated activities, as well as the appropriate NCQA and contractual standards. This audit may be performed on-site or via desktop review. Consideration will be given to utilizing a current Industry Collaboration Effort (ICE) Shared Credentialing Audit, if relevant CalOptima programs are included. Additional documentation may need to be provided to complete the audit.

2. The annual audit shall include the review of policies and procedures utilizing the delegation oversight annual audit tool. This audit will include, but not be limited to:

   a. A review of Delegated Entity's Peer Review Body meeting minutes, which shall be conducted for Credentialing and Recredentialing activities;

   b. A review to confirm the Delegated Entity's reporting procedure to CalOptima when there is action taken against a practitioner that relates to professional behavior or clinical competence, and suspensions, terminations, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG), or the National Practitioner Data Bank (NPDB).)

3. An annual file review is also conducted utilizing the Credentialing and Recredentialing file review tool:

   a. CalOptima shall apply the 8/30 methodology when conducting the annual file review. CalOptima will select a random sample of thirty (30) Credentialing and thirty (30) Recredentialing files, and will provide the organization with the file selection.

      i. Eight (8) of each file type will be randomly chosen for the initial review. Credentialing requirements applicable to both file types are scored for all files. CalOptima shall review files until it has sufficient results to score based on the 8/30 methodology.

b. If the requirement applies only to initial Credentialing files (e.g., work history) or to Recredentialing files (e.g., Recredentialing cycle length), the requirement is scored 'Not Applicable' for the file type that does not apply. CalOptima shall score only applicable files until it has sufficient results to score based on its 8/30 methodology.

i. If fewer than thirty (30) Practitioners were Credentialed or Recredentialed within the look back period, CalOptima shall audit the universe of files rather than a sample.

c. CalOptima shall review documentation of substantive evaluation and action plans, if needed.

d. If the Delegated Entity does not have any files for Credentialing or Recredentialing between audit cycles, CalOptima will not perform an annual audit, but instead shall require the Delegated Entity to meet all other delegation oversight requirements, and provide documentation that the Delegated Entity did not Credential or Recredential Practitioners between audit cycles.

4. Based on the results of the annual audit, CalOptima may take the following actions:

a. Require a Delegated Entity to respond to and submit a CAP addressing all areas of deficiency as determined by CalOptima in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan;

b. Audit the Delegated Entity's implementation and completion of an approved CAP, and any performance area(s) addressed in the CAP;

c. Impose Sanctions against a Delegated Entity, in accordance with CalOptima Policy HH.2002Δ: Sanctions;

d. Initiate the de-delegation process in accordance with Section III.F of this policy.

5. CalOptima staff shall report findings from oversight reviews and CAPs to the AOC with recommendations for follow-up activities.

F. De-Delegation

1. The Audit & Oversight Credentialing Auditor shall review CAPs that do not meet the compliance threshold or are classified as 'delinquent,' and shall make appropriate recommendations to the AOC.

2. The AOC shall review a Delegated Entity's Delegation status based on the CAP timeline and level of achievement.

3. If a Delegated Entity fails to achieve compliance within the timeframes set forth in the CAP, the AOC may recommend de-delegation of Credentialing and Recredentialing.

4. If the AOC recommends de-delegation of Credentialing and Recredentialing activities from the Delegated Entity, and Compliance Committee approves the recommendation, CalOptima shall:

a. Provide the Delegated Entity with thirty (30) calendar days written notice of CalOptima's intent to de-delegate;

b. Inform Practitioners of the de-delegation and instructions for continued services;

c. Adjust the Delegated Entity's payments as appropriate to the de-delegated status of Credentialing and Re-credentialing activities; and

d. Prepare appropriate CalOptima departments to perform the de-delegated Credentialing and Recredentialing activities; and

e. CalOptima shall inform the Delegated Entity and Practitioners of their right to file an Appeal.

5. A Delegated Entity shall cooperate with CalOptima to ensure smooth transition and continuous care for Members during the de-delegation transition period.

6. CalOptima may re-evaluate a Delegated Entity's ability to perform delegated Credentialing and Recredentialing activities no sooner than twelve (12) months after de-delegation.

a. CalOptima shall utilize the pre-delegation Readiness Assessment process, as described in Section III.B of this policy.

b. CalOptima shall delegate Credentialing and Recredentialing activities to Delegated Entity based on the pre-delegation Readiness Assessment results.

c. The Director of Audit & Oversight shall present the re-audit pre-delegation Readiness Assessment to the AOC.

d. If the AOC recommends approval of Delegation of Credentialing and Recredentialing activities to the Delegated Entity, and the Compliance Committee approves the recommendation, CalOptima shall re-delegate such activities, and adjust the Delegated Entity's payment accordingly.

e. If the AOC recommends denial of re-delegation of Credentialing and Recredentialing activities to the Delegated Entity, it may also recommend additional Sanctions on the Delegated Entity, up to and including termination of the Contract for Health Care Services, to the Compliance Committee for final action.

7. CalOptima shall inform the Delegated Entity and Practitioners of their right to file an Appeal.

H. Exchange of Information

1. CalOptima may, at its discretion, share copies of a report received from a Delegated Entity regarding an adverse action, if CalOptima deems that such report may protect the medical care of a Member.

a. Such reports may include, but are not limited to, action taken against a Practitioner that relates to professional behavior or clinical competence, suspensions, terminations, legal

actions, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG) or the National Practitioner Data Bank (NPDB)).

b. The provision of any such report to another Delegated Entity shall not relieve the Delegated Entity of an independent duty to comply with Credentialing procedures or to query or file a report with state or federal regulatory agencies.

2. CalOptima retains the right to review all components of a Delegated Entity's file.

I. Monitoring

1. CalOptima shall monitor a Delegated Entity's Credentialing and Recredentialing activities through reports, monthly file reviews, and continuous improvement activities.

a. Monthly Credentialing Universe

i. The Monthly Credentialing Universe is due to CalOptima on the second (2nd) day of every month.

a) Universes must be submitted via FTP server to the 'HN_Reporting' folder utilizing the instructed naming conventions. Effective January 1, 2016, a single universe template will be utilized for reporting all contracted lines of business.

b. Monthly File Review

i. On a monthly basis, CalOptima will review Credentialing and Recredentialing files for each delegate. Delegates that are NCQA-Certified or Accredited are exempt from the Monthly File Review, but are still required to submit Monthly Credentialing Universes.

a) The CalOptima auditor will select the following file types at random from the Monthly Credentialing Universe submitted:

1. Eight (8) Credentialing Files; and

2. Eight (8) Recredentialing Files.

ii. The CalOptima auditor will notify the Delegated Entity via email of the file selection no later than the fourth (4th) of every month.

iii. The Delegated Entity shall submit the selected Credentialing and Recredentialing files to CalOptima on the tenth (10th) of every month.

a) Credentialing and Recredentialing files must be submitted via FTP server into the 'HN_Reporting' folder utilizing the instructed naming conventions.

2. A Delegated Entity shall submit reports to CalOptima on a periodic basis, as specified by CalOptima, including, but not limited to, those reports based on the mutually agreed-upon Delegation Agreement:

    a. Reports shall include, but are not limited to:

        i. Monthly Credentialing and Recredentialing reports;

        ii. A list of all active Practitioners on an annual basis;

        iii. Verification of Board Certification for Practitioners who claim Board Certification status; and

        iv. Annual reports of any Sub-Delegate's performance, if CalOptima approved such sub-delegation.

    b. A Delegated Entity shall submit such reports to CalOptima in accordance with the Delegation Agreement

        i. CalOptima shall require a Delegated Entity:

            a) To notify CalOptima immediately of any investigation by a regulatory or licensing agency of a Practitioner that relates to professional behavior or clinical competence, and suspensions, terminations, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG)) or the National Practitioner Data Bank (NPDB)).

            b) To provide CalOptima copies of any California Business and Professions Code, Section 805 reports, or National Practitioner Data Bank reports, at the time the report is filed.

IV. ATTACHMENTS

A. Monthly Credentialing Universe

V. REFERENCES

A. 2016-2017 NCQA Standards for the Accreditation
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal Health Network Service Agreement
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
F. California Business and Professions Code, Section 805
G. CalOptima Policy AA.1000: Glossary of Terms

H. CalOptima Policy MA.1001: Glossary of Terms
I. CalOptima Policy CMC.1001 Glossary of Terms
J. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing
K. CalOptima Policy HH.2002Δ: Sanctions
L. CalOptima Policy HH.2005Δ: Corrective Action Plan
M. Medicare Managed Care Manual, Chapter 11, Section 110.2Title 28, California Code of Regulations, Section 1300.70(b)(1)(D) and (E)
N. Title 42, Code of Federal Regulations, Section 438.230(b)

VI. REGULATORY AGENCY APPROVALS

A. 06/29/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/ REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/1995	GG.1605	Credentialing, Monitoring Health Network Compliance	Medi-Cal
Revised	08/1998	GG.1605	Credentialing, Monitoring Health Network Compliance	Medi-Cal
Revised	02/2001	GG.1605	Delegation and Oversight of Credentialing and Recredentialing Activities	Medi-Cal
Revised	07/01/2007	GG.1605	Delegation and Oversight of Credentialing and Recredentialing Activities	Medi-Cal
Revised	06/01/2014	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2015	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	12/07/2017	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consists of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance Officer; and Executive Director of Human Resources.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. First Tier, Downstream and Related Entities and/or CalOptima departments may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Delegated Entity	An entity, such as a Health Network, Pharmacy Benefits Manager (PBM), Managed Behavioral Health Organization (MBHO) or other entity to whom CalOptima delegates Member care or administrative responsibilities. Additionally, any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services. Functions may be delegated by written contract only and only as permitted by CMS and/or State governmental agencies, as applicable to the specific program.
Delegation	A legal assignment to another party of the responsibility for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements and obligations pertaining to the delegated functions.

Term	Definition
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima program.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia(“PHCs”), Shared Risk Medical Groups (“SRGs”), and Health Maintenance Organizations(“HMOs”).
Member	A beneficiary who is enrolled in a CalOptima program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Recredentialing	The process by which the qualifications of Practitioners are verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Practitioner	An individual who provides covered services pursuant to a state license, including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist.
Readiness Assessment	An assessment conducted by a Review Team prior to the effective date of a Health Network's or other contracted entity's Contract with CalOptima of a Health Network or contracted entity's compliance with all or a specified number of operational functional areas as determined by CalOptima.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima’s management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Term	Definition
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier, Downstream or Related Entity's(FDR) or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Sub-Delegate	An entity that has entered into a written agreement with a Health Network or other delegated Provider to perform certain operational functions that would otherwise be required to be performed by CalOptima, the Health Network or other delegated Provider, in order to meet contractual and/or regulatory obligations. Examples of a Sub-Delegate may include, but are not limited to, a management services organization (MSO) or a credentials verification organization (CVO).

1

Delegate Name: **ABC Medical Group**

Credentialing Universe

Medi-Cal (Y/N)	OneCare (Y/N)	OneCare Connect (Y/N)	License #	Last Name	First name	Middle Initial	Type (PCP, SCP, Mid-level)	Primary Contracted Specialty	Initial Decision Date MM/DD/YYYY	License to Practice (Y/N)

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Reporting Month/Year: **January 2016**

DEA/CDS Certificate (Y/N or N/A)	Board Certification (Y/N)	Board Cert Iss Date MM/DD/YYYY	Board Cert Exp Date MM/DD/YYYY (Lifetime = N/A)	Education & Training (Y/N)	Work History (Y/N)	Malpractice History (Y/N or N/A)	Reasons for Inability to Perform (Y/N or N/A)

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Lack of Drug Use (Y/N or N/A)	History of Loss of License (Y/N or N/A)	History of Felony Convictions (Y/N or N/A)	History of Loss or Limitation of Privileges (Y/N or N/A)	Current Malpractice Coverage (Y/N)	State sanctions, restrictions on licensure/practice (Y/N or N/A)	Medicare/Medicaid Sanctions (Y/N)

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Initial Site Visit MM/DD/YYYY	Evaluation of Medical Record Keeping Practices (Y/N)	Hospital Privileges (Y/N or N/A)	Current, signed attestation confirming the correctness and completeness of the application MM/DD/YYYY	Is Practitioner a designated HIV Specialist? (Y/N)	License Type

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Policy #:	HH.2015
Title:	**Health Networks Claims Processing**
Department:	Office of Compliance
Section:	~~Compliance~~Audit & Oversight ~~(External)~~
CEO Approval:	Michael Schrader
Effective Date:	01/01/07
Last Review Date:	12/07/17
Last Revised Date:	12/07/17 ~~01/01/16~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect
~~Medi-Cal~~ ~~OneCare~~	~~OneCare Connect~~

I. PURPOSE

~~To ensure~~This policy ensures Health Network compliance with claims settlement practices.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Clean Claim~~	~~A claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, including the substantiating documentation needed to meet the requirements for encounter data, or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under Medi-Cal requirements.~~ ~~A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.~~
~~Complete Claim~~	~~A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: reasonably relevant information and information necessary to determine payer liability as defined in Title 28, California Code of Regulations (CCR) section 1300.71 (a)(10) and (a)(l11)and as described in 28 CCR sections 1300.71(a)(2)(A) (F).~~
~~Contested Claim~~	~~A claim submitted for payment that is considered an incomplete claim submission and that is contested by the health plan as a result of the claim not containing all reasonably relevant information to determine payer liability.~~
~~Contracted Provider~~	~~A Provider who is obligated by written contract to provide Covered Services to Members.~~
~~Coordination of Benefits~~	~~A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan.~~
~~Corrective Action Plan (CAP)~~	~~A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.~~

~~Term~~	~~Definition~~
~~Covered Services~~	~~**Medi-Cal**~~ ~~Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors and funded by CalOptima, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.~~ ~~**OneCare**~~ ~~Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract.~~ ~~**OneCare Connect**~~ ~~Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).~~
~~Denied Claim~~	~~A claim for which payment could not be made due to some defect, such as the patient was not a Member, the services were not covered services, the claim was not filed in a timely manner, etc.~~
~~Emergency Medical Condition~~	~~A medical condition that is manifested 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:~~ ~~- Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy;~~ ~~- Serious impairment to bodily functions; and/or~~ ~~- Serious dysfunction of any bodily organ or part.~~
~~Emergency Services~~	~~Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.~~

~~Term~~	~~Definition~~
~~Family Planning Services~~	~~Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to:~~ ~~1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning;~~ ~~2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures;~~ ~~3. Patient visits for the purpose of Family Planning;~~ ~~4. Family Planning counseling services provided during regular patient visit;~~ ~~5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices;~~ ~~6. Tubal ligations;~~ ~~7. Vasectomies;~~ ~~8. Contraceptive drugs or devices; and~~ ~~9. Treatment for the complications resulting from previous Family Planning procedures.~~ ~~Family Planning does not include services for the treatment of infertility or reversal of sterilization.~~
~~Focused Review~~	~~An audit that specifically targets areas of potential deficiency.~~
~~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 Cal Optima to provide Covered Services to Members assigned to that Health Network.~~The contracted health networks of CalOptima, including~~Physician Hospital Consortia~~(“PHCs”), ~~Shared Risk Medical Groups (“SRGs”), and Health Maintenance~~Organizations~~(“HMOs”).~~
~~Member~~	~~A~~ ~~A beneficiary~~who is enrolled in a CalOptima program, excluding ~~member of the Program for All Inclusive Care for the Elderly (PACE).~~**~~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 Cal Optima program.~~
~~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.~~
~~Non-Contracted Provider~~	~~A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.~~
~~Unclean Claim~~	~~A claim from a Provider that does not have all the required data elements, documentation, or information necessary to process the claim or make a final disposition. Unclean claim shall have the same meaning as incomplete claim submission.~~

~~III.~~II. POLICY

A. A Health Network shall establish and maintain administrative processes, or contract with a claims processing organization, to accept and adjudicate claims for health care services provided to

Members, in accordance with the Health Network's contract with CalOptima, as well as the provisions of this policy and applicable laws and regulations.

B. A Health Network shall ensure timely compliance with claims payment obligations and claims settlement practices.

C. A Health Network shall not impose a deadline for the receipt of a claim ~~that~~:

~~C.~~1. Medi-Cal: That is less than ninety (90) calendar days for a participating Provider and one hundred eighty (180) calendar days for a non-participating Provider after the date of service, except as required by state or federal law or regulation.

2. OneCare and OneCare Connect:

a. For a Non-Contracted provider that is less than twelve (12) months or one (1) calendar year after the date the services were furnished; and

b. For a Contracted Provider that is less than the time frame specified in the contracted provider agreement. If the contracted provider agreement does not specify a timeframe, the Contracted Provider shall submit a claim within twelve (12) months, or one (1) calendar year after the date the services were furnished.

D. A Health Network shall identify and acknowledge the receipt of each claim, whether or not it is a Complete Claim, and disclose the recorded date of receipt in the same manner as the claim was submitted. Alternatively, the Health Network may provide an electronic means, by telephone, website, or another accessible method of notification, by which the Provider may readily confirm the Health Network's receipt of the claim and the recorded date of receipt within the time frames specified in Section III~~V~~.C. of this policy.

E. Claims Processing Timelines

1. Medi-Cal

~~1.~~a. A Health Network shall process and adjudicate ninety percent (90%) of Clean Claims for Covered Services provided to a Member within thirty (30) calendar days after the Health Network's receipt of such Clean Claims.

b. A Health Network shall process and adjudicate one hundred percent (100%) of Contracted and Non-Contracted Clean and Unclean Claims for Covered Services provided to a Member within forty–five (45) calendar days after the Health Network's receipt of such claims.

~~2.~~c. A Health Network shall process and adjudicate ninety-nine percent (99%) of claims for Covered Services provided to a Member within ninety (90) calendar days after the Health Network's receipt of the claim.

~~3.~~d. A Health Network shall notify a Provider of an Unclean Claim for Covered Services provided to a Member within forty-five (45) business days after the Health Network's receipt of the claim. If the Health Network fails to notify the Provider of the Unclean Claim, the Health Network shall consider the claim a Clean Claim and shall pay in accordance with the timelines for Clean Claims as set forth in this policy.

2. OneCare

a. A Health Network shall ~~not request reimbursement~~process and adjudicate ninety-five percent (95%) of Clean Claims for ~~the overpayment of~~ Covered Services provided to a ~~claim, including requests made pursuant to Health and Safety Code, Section 1371.1, unless the~~ Member within thirty (30) days after the Health Network's receipt of such Clean Claims.

i. For claims not furnished under a written agreement with the submitting provider, a Health Network ~~sends a written request for reimbursement to the Provider~~shall process ninety-nine percent (99%) of Clean Claims for Covered Services provided to a Member within thirty (30) days after the Health Network's receipt of such Clean Claims.

b. All other claims from non-contracted Providers shall be paid or denied within sixty (60) calendar days from the date of the request. ~~A Health Network shall process ninety-five percent (95%) of claims for Covered Services provided to a Member within sixty (60) calendar days from the day of the request of such Clean and Unclean Claims.~~

c. A Health Network shall adhere to the Medicare Claims Processing Manual for the handling of all incomplete or invalid claims.

3. OneCare Connect

a. A Health Network shall process and adjudicate ninety-five percent (95%) of claims for Covered Services provided to a Member within thirty (30) calendar days after the Health Network's receipt of such Clean Claims.

b. A Health Network shall process ninety-nine percent (99%) of claims for Covered Services provided to a Member within ninety (90) calendar days from the day of the request of such Clean Claims.

c. A Health Network shall process one hundred percent (100%) of claims from Non-Contracted Providers paid or denied for Covered Services provided to a Member within sixty (60) calendar days from the day of the request of such Unclean claims.

F. Overpayments or adjustments must be identified and written notification sent to Providers of Service within three hundred and sixty-five (365) days ~~after the date of payment on the overpaid claim. The three hundred and sixty-five (365) day time limit shall not apply if the overpayment~~of the date the original claim was ~~caused in whole or in part by fraud or misrepresentation on the part of the Provider~~paid. Providers of service must either contest or pay requested monies within (30) business days of receipt of the notification of overpayment or adjustment pursuant to Health and Safety Code, Section 1371.1. In addition, -interest shall accrue at the rate of 10 percent (10%) per annum beginning with the first calendar day after the thirty (30) business day period.

G. A Health Network shall pay interest and applicable penalties ~~on~~.

~~G.~~1. Medi-Cal: For all uncontested claims not paid within forty-five (45) business days, in accordance with Section ~~IV~~III.E.~~D~~ of this policy. The interest rate is determined by California Health and Safety Code~~, Section~~ section 1371~~.~~ or 1371.35, whichever is applicable.

2. OneCare and OneCare Connect: For all Non-Contracted Claims not paid within thirty (30) calendar days and (60) calendar days for all Contracted Claims after the day of receipt of the claim on a per claim basis, in accordance with Section III.~~D~~E. of this policy. The interest rate for all Non-Contracted Claims is determined by Title 31 of the United States Code (U.S. Code), S~~s~~ection 3902(a), and Code of Federal Regulations (CFR), S~~s~~ection 422.520 in accordance with S~~s~~ections 1816(c)(2)(B) and 1842(c)(2)(B) for the period beginning on the thirty-first (31st) day after receipt and ending on the date the Health Network makes payment. The interest rate for all Contracted Claims is determined by the provisions of the contract between the Health Network and the P~~p~~rovider.

H. In the event the Health Network fails to timely and accurately reimburse its claims and the Health Network has not established an approved Corrective Action Plan (CAP) consistent with Health and Safety Code, Section 1375.4(b)(4) and CalOptima Policies HH.~~2005: Health Network~~2005Δ: Corrective Action Plan, and HH.~~2002~~2002Δ: Sanctions, CalOptima shall take appropriate corrective action, which may include, but is not limited, de-delegation of claims payment.

I. A Health Network shall not improperly deny, adjust, or contest a claim and shall provide a clear and accurate written explanation of the specific reasons for the action taken.

J. A Health Network shall establish and maintain a fair, fast, and cost-effective dispute resolution mechanism to process and resolve Provider disputes that meet the requirements of CalOptima ~~Policy HH.1101: Provider Complaint.~~PoliciesHH.1101: Provider Complaint and MA.9006: Provider Complaint Process. ~~, as well as and Title 42, Code of Federal Regulations (CFR), sections 405.927-405.942 (for OneCare and OneCare Connect).~~ A Health Network shall make all records, notes, and documents regarding its Provider dispute resolution mechanism(s) and the resolution of its Provider disputes available to CalOptima and ~~the Department of Health Care Services (DHCS).~~any requesting regulatory agency.

K. A Health Network shall resolve its Provider disputes in a timely manner, including the issuance of a written decision, in accordance with CalOptima ~~Policy HH~~Policies HH.1101: Provider Complaint~~.~~ and MA.9006: Provider Complaint Process, ~~as well as and Title 42, CFR, sections 405.927-405.942 (for OneCare and OneCare Connect).~~. CalOptima shall monitor and ensure the administration of the Health Network's dispute resolution mechanism(s) and for the timely resolution of Provider disputes.

L. A Health Network shall not engage in any practices, policies, or procedures that may constitute a basis for a finding of a demonstrable and unjust payment pattern or unfair payment pattern that results in repeated delays in the adjudication and correct reimbursement of Provider claims.

M. A Health Network shall submit to CalOptima all required claims performance reports within fifteen (15) calendar days after the close of each calendar month or thirty (30) calendar days after the close of each calendar quarter in a format specified by CalOptima. Required reports shall, at a minimum, disclose the Health Network's compliance status with the provisions of this policy, the California Code of Regulations, ~~and~~ the Health and Safety Code, Code of Federal Regulations (CFR) and Centers for Medicare & Medicaid Services (CMS) requirements.

N. For OneCare and OneCare Connect: A Health Network shall reimburse a provider for Emergency Services and, if applicable, its affiliated providers for related services at the lowest level of emergency department evaluation and management (Physician's Current Procedural Terminology

(CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

~~IV.~~III. PROCEDURE

A. Claim Filing Deadlines

1. Medi-Cal: A Health Network shall not impose a deadline for the receipt of a claim that is less than ninety (90) calendar days for a Participating Provider and one hundred and eighty (180) calendar days for a Non-participating Provider after the date of service, except as required by state or federal law or regulation.

2. One-Care and OneCare Connect: For a Non-Contracted provider that is less than twelve (12) months or one (1) calendar year after the date the services were furnished. For a Contracted Provider that is less than the timeframe specified in the contracted provider agreement. If the contracted provider agreement does not specify a timeframe, the Contracted Provider shall submit a claim within twelve (12) months, or one (1) calendar year after the date the services were furnished.

~~2.~~3. If a Health Network denies a claim because it was filed beyond the claim filing deadline, the Health Network shall, upon a Provider's submission of a Provider dispute pursuant to Title 28, California Code of Regulations, Section 1300.71.38, and the demonstration of good cause for the delay, accept and adjudicate the claim in accordance with Health and Safety Code, Sections 1371 or 1371.35, whichever is applicable.

~~3.~~4. If the Health Network is not the primary payer under coordination of benefits, the Health Network shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payer that is less than ninety (90) calendar days from the date of payment or date of contest, denial, or notice from the primary payer.

B. Misdirected Claims

1. For a Provider claim involving Emergency Services or Family Planning Services that is incorrectly sent to a Health Network, the Health Network shall forward the claim to the appropriate Health Network within ten (10) business days after receipt of the claim.

2. For a Provider Claim that does not involve Emergency Services or Family Planning Services that is incorrectly sent to a Health Network, and the Provider that filed the claim is a ~~contracted~~Contracted Provider, within ten (10) business days of the receipt of the claim the Health Network shall either:

   a. Medi-Cal: Send the Provider a notice of denial, within forty-five (45) business days, with instructions to bill the appropriate Health Network; or

   b. OneCare and OneCare Connect: Send the Provider a notice of denial, within thirty (30) business days for Non-Contracted Claims and (60) business days for Contracted Claims, with instructions to bill the appropriate Health Network; or

   ~~b.~~c. Forward the claim to the appropriate Health Network.

3. In all other cases, for claims incorrectly sent to a Health Network, the Health Network shall forward the claim to the appropriate Health Network within ten (10) business days of the receipt of the claim.

4. If a claim is sent to a Health Network and CalOptima is responsible for adjudicating the claim, the Health Network shall forward the claim to CalOptima within ten (10) business days after the receipt of the claim incorrectly sent to the Health Network.

C. Acknowledgment of Claims

1. In the case of an electronic claim, the Health Network shall identify and acknowledge the claim within two (2) business days after the date of receipt of the claim by the office designated to receive claims. Electronic claims received by 5- p.m. on a business day, or by closing time if the Health Network routinely ends its public business day between 4- p.m. and 5- p.m., must be considered as received on that date.

2. In the case of a paper claim, the Health Network shall identify and acknowledge the claim within fifteen (15) business days after the date of receipt of the claim by the office designated to receive claims. Paper claims received by 5- p.m. on a business day, or by closing time if the Health Network routinely ends its public business day between 4 p.m. and 5p.m., must be considered as received on that date. A paper claim received after the routine close of business between 4 p.m. and 5 p.m. is considered received on the next business day.

3. If a Provider submits a claim using a Health Network's claims clearinghouse, the Health Network's identification and acknowledgment to the clearinghouse within the time frames set forth in subparagraph 1 and 2 of this section, whichever is applicable, shall constitute compliance.

D. Interest on Late Claims

1. Medi-Cal

~~1.~~a. Interest shall begin to accrue on the forty-sixth (46th) business day and is calculated based on calendar days.

~~2.~~b. A Health Network shall automatically include, for late payment on a Complete Claim for Emergency Services and care, the greater of fifteen dollars ($15) for each twelve (12) month period or portion thereof on a non-prorated basis, or interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

~~3.~~c. A Health Network shall automatically include, for late payments on all other claims other than Complete Claims for Emergency Services and care, interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

~~4.~~d. If the interest due on an individual claim is less than two dollars ($2), a Health Network may wait until the close of the calendar month and make a lump interest payment for all late claim payments during that time period. The Health Network shall make lump interest payments within ten (10) calendar days of the calendar month's end.

~~5.~~e. If a Health Network fails to automatically include the interest due on a late claim payment, the Health Network shall pay the Provider a ten dollar ($10) penalty for that late claim, in addition to any amounts due.

2. OneCare and OneCare Connect

a. Interest shall begin to accrue on the thirty-first (31st) business day for Non-Contracted Claims, (60) days for Contracted Claims and is calculated based on calendar days. Interest is paid at the rate used for section 3902(a) of Title 3l, U.S. Code and rounded to the nearest penny. The interest rate is determined by the applicable rate on the day of payment. Interest shall be calculated using the following formula:

i. Payment amount x rate x days divided by 365 (366 in a leap year) = interest payment

E. Denying, Adjusting, or Contesting a Claim

1. A Health Network may contest or deny a claim, or portion thereof, by notifying the Provider, in writing, that the claim is contested or denied, within forty-five (45) business days after the date of receipt of the claim by the Health Network~~.~~ for the Medi-Cal program and within thirty (45) business days for Non-Contracted Claims and (60) calendar days for Non-Contracted Claims for OneCare and OneCare Connect.

2. If the Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, the Health Network shall provide a clear, accurate, and written explanation of the necessity for the request. If the Health Network subsequently denies the claim based on the Provider's failure to provide the requested Medical Records or other information, any dispute arising from the denial of such claim shall be handled as a Provider dispute ~~in accordance with Title 28, California Code of Regulations, Section 1300.71.38.~~resolution process..

3. If a Health Network fails to provide the Provider with written notice that a claim has been contested or denied within the allowable time period pursuant to Section ~~IV~~III.E.1 of this policy, or requests information from the Provider that is not reasonably relevant information and requests information from a third party that is in excess of the information necessary to determine payer liability, but ultimately pays the claim in whole or in part, the Health Network shall compute the interest or impose a penalty pursuant to Section ~~IV~~III.D of this policy.

4. A request for information necessary to determine payer liability from a third party shall not extend the time for reimbursement or the time for contesting or denying claims. The Health Network shall either contest or deny within the time frames set forth in Section III~~V~~.E.1 of this policy, in writing, incomplete claims and claims for which information necessary to determine payer liability that has been requested, which are held or pended awaiting receipt of additional information. The Health Network shall identify in the denial or contest the individual or entity that was requested to submit information, the specific documents requested and the reason(s) why the information is necessary to determine payer liability.

F. Reimbursement for the Overpayment of Medi-Cal and OneCare Connect Claims ~~()~~

1. If a Health Network determines that it has overpaid a claim, it shall notify the Provider, in

writing, through a separate notice clearly identifying the claim, the name of the patient, the date of service and including a clear explanation of the basis upon which the Health Network believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

2. If the Provider contests the Health Network's notice of reimbursement of the overpayment of a claim, the Provider, within thirty (30) business days of the receipt of the notice of overpayment of a claim, shall send written notice to the Health Network stating the basis upon which the Provider believes that the claim was not overpaid. The Health Network shall receive and process the contested notice of overpayment of a claim as a Provider dispute pursuant to Title 28, California Code of Regulations, Section 1300.71.38 and CalOptima Policy HH.1101: CalOptima Provider Complaint and CalOptima Policy MA.9006: Provider Complaint Process, as applicable.

3. If the Provider does not contest the Health Network's notice of reimbursement of the overpayment of a claim, the Provider shall reimburse the Health Network within thirty (30) business days of the receipt by the Provider of the notice of overpayment of a claim.

~~If~~

4. For the Medi-Cal program, if the Provider does not reimburse the Health Network for the overpayment of a claim within thirty (30) business days after receipt of the Health Network's notice, interest shall accrue at the rate of ten percent (10%) per annum beginning with the first (1st) calendar day after the thirty (30) business day period.

5. A Health Network may only offset an uncontested notice of reimbursement of the overpayment of a claim against a Provider's current claim submission when:

   a. The Provider fails to reimburse the Health Network within the timeframe in Section III~~V~~.F.3 of this policy; and

   b. The Provider has entered into a written contract specifically authorizing the Health Network to offset an uncontested notice of overpayment of a claim from the current claim submissions. In the event that an overpayment of a claim or claims is offset against a Provider's current claim or claims pursuant to this section, the Health Network shall provide the Provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

6. *Conlan* claims and Coordination of Benefits recoveries shall not be considered overpayments under this Policy, and shall be processed in accordance with CalOptima Policy FF.2005: Conlan, Member Reimbursement, and CalOptima Policy FF.2003: Coordination of Benefits, respectively.

G. A Health Network shall provide a Participating Provider upon contracting, annually, and upon the Participating Provider's written request, the following information in a paper or electronic format, which may include a Website containing this information, or another mutually agreeable accessible format:

1. Directions, including the mailing address, email address, and facsimile number, for the electronic transmission (if available), physical delivery, and mailing of claims, all claim submission requirements including a list of commonly required attachments, supplemental

information and documentation consistent with reasonably relevant information, instructions for confirming the Health Network's receipt of claims consistent Section IIIV.C of this policy, and a telephone number for claims inquiries and filing information;

2. The identity of the office responsible for receiving and resolving Provider disputes;

3. Directions, including the mailing address, email address, and facsimile number for the electronic transmission (if available), physical delivery, and mailing of Provider disputes and all claim dispute requirements, the timeframe for the Health Network's acknowledgement of the receipt of a Provider dispute and a telephone number for provider dispute inquiries and filing information;

4. Directions for filing substantially similar multiple claims disputes and other billing or contractual disputes in batches as a single Provider dispute that includes a numbering scheme identifying each dispute contained in the bundled case.

5. Complete fee schedule for the Participating Provider consistent with the disclosures specified in Title 28, California Code of Regulations, Section 1300.75.4.1(b); and

6. Detailed payment policies and procedures and rules and non-standard coding methodologies used to adjudicate claims, which shall unless otherwise prohibited by state law:

   a. When available, be consistent with Current Procedural Terminology (CPT) and Medi-Cal or Medicare Coding, the standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies, and major credentialing organizations;

   b. Clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments; and

   c. At a minimum, clearly and accurately state the policies regarding the following:

      i. Consolidation of multiple services or charges and payment adjustments due to coding changes;

      ii. Reimbursement for multiple procedures;

      iii. Reimbursement for assistant surgeons;

      iv. Reimbursement for the administration of immunizations and injectable medications; and

      v. Recognition of CPT and Medi-Cal modifiers.

H. A Health Network shall provide a minimum of forty-five (45) days prior written notice before instituting any changes, amendments, or modifications in the disclosures pursuant to Ssection IIIV.G of this policy.

1. A Health Network, with the agreement of the Participating Provider, may utilize alternate transmission methods to deliver any disclosure required by this policy, as long as the Participating Provider can readily determine and verify that the required disclosures have been transmitted or are accessible and the transmission method complies with all applicable state and federal laws and regulations.

2. The Health Network shall supplement its electronic transmission with paper communication that satisfies the disclosure requirements pursuant to any limitations on the Health Network's ability to electronically transmit any required disclosures as found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended.

I. Managing Claims for Timeliness Compliance

1. A Health Network shall monitor the paid, denied, and pended claims reports daily to ensure that claims are correctly processed and coded, and that the claims meet the timeline requirements.

2. A Health Network shall ensure that timeline reports are completed weekly and shall develop specific action plans to address any deficiencies noted in such reports.

3. A Health Network shall provide the results of any deficiencies noted in a claims audit conducted by the Health Network.

4. A Health Network shall document and maintain action plans related to individual examiners or to the unit as a whole for periodic review by CalOptima or the Health Network.

J. Oversight

1. CalOptima shall conduct a claims audit of a Health Network to ensure the Health Network's compliance with statutory, regulatory, contractual, CalOptima policy and any other requirements related to the CalOptima program.

   a. CalOptima shall conduct a readiness assessment of a Health Network prior to the effective date of the Health Network contract.

   b. CalOptima shall conduct an annual claims audit of a Health Network.

   c. CalOptima may conduct a claims audit of a Health Network that changes its management company.

   d. CalOptima may conduct additional claims audits as necessary.

2. Scope of claims audit

   a. CalOptima shall, at its discretion, determine the scope and timing of its periodic and regular claims audits.

   b. A claims audit may cover one (1) or more functional departments, processes, or delegated functions.

3. Pre-review communications or notice

a. CalOptima may, at its discretion, provide a Health Network with advance notice of a claims audit.

b. ~~Prior~~If advance notification of a claims audit is given, prior to the date of the review, ~~the CalOptima~~CalOptima's Office of Compliance Department shall notify a~~-~~ Health Network, in writing, of the following:

i. Date and time of the claims audit;

ii. Areas for review;

iii. Reports and questionnaires that the Health Network shall submit to CalOptima prior to the claims audit; and

iv. Documentation the Health Network shall provide at the time of the claims audit.

c. CalOptima shall make all audit selections from reports submitted by a Health Network and shall return such reports to the Health Network in a timely manner.

4. Claims audit

a. A Health Network shall ensure that the documents are organized in the order of selection provided by CalOptima and accessible on the day of the claims audit. CalOptima may request copies of the documents from the Health Network.

b. A Health Network shall ensure that appropriateness measures include elements pertaining to the validity and accuracy of claims adjudication (payment, denial or contest) and dispute resolution and includes, but is not limited to, accuracy and appropriateness of claims payment, including automatic payment of interest as applicable; validity of denial reasons, documentation and written notification; accuracy, validity and appropriateness of adjustments, including applicability and payment of interest and notifications; mandatory disclosures and notification language for denials, adjusted claims and disputes and other regulatory and contractual requirements; accuracy and appropriateness of notifications, resolution and written determination and other regulatory or contractual requirements as it pertains to the resolution of disputes; or other measures that may constitute unfair payment practices.

~~b.~~c. If a Health Network and its delegates, subcontractors, and partners are unable to furnish all required documents requested by CalOptima, CalOptima may score missing documents as non-compliant.

~~c.~~d. A Health Network shall make staff available during the claims audit to answer questions and provide necessary information to CalOptima in order to complete the claims audit.

~~d.~~e. For auditing purposes, a Health Network is considered compliant if a Health Network ~~scores at least ninety percent (90%) for timeliness of payment of clean claims for covered services provided to a member within thirty (30) calendar days, and at least ninety-nine percent (99%) of paid claims within ninety (90) calendar days. A compliant score for all other audited categories will be no less than the State and Federal regulatory standard for~~

~~the audited area, but may be higher than the regulatory standard as deemed by CalOptima's Audit and Oversight Department.~~ensures that the requirements of Section ~~II~~I.E of this policy are met. For check cashing, a Health Network shall ensure that at least eighty percent (80%) of checks clear a banking institution within fourteen (14) calendar days after the date the check is mailed. For claims payment timelines, a Health Network shall ensure that the requirements of Section III.E of this policy are met.

6. Report issuance

   a. The CalOptima Compliance Department shall provide a Health Network with a post-audit letter containing the audit findings and recommendations within thirty (30) calendar days after the completion of the claims audit.

   b. CalOptima shall retain the right to publish data obtained from a Health Network claims audit, and may distribute such data to a Member or to the general public without further notice to or consent from the Health Network.

7. Action based on the Health Network claims audit

   a. If CalOptima determines that a Health Network is non-compliant with the provisions of this policy, CalOptima shall conduct a Focused Review within one hundred eighty (180) calendar days after the audit.

   b. CalOptima may require a Health Network to submit a CAP addressing all areas of deficiency as determined by CalOptima, in accordance with CalOptima Policy HH.~~2005: Health Networks~~2005Δ: Corrective Action Plan.

   c. CalOptima may impose remedies such as, but not limited to, de-delegation of claims payment, or may impose sanctions against a Health Network pursuant to CalOptima Policy HH.~~2002: Health Network Sanction~~2002Δ: Sanctions.

   d. ~~The CalOptima Compliance Department shall report its findings~~Findings and CAP(s) from a Health ~~Network claims~~Network's Claims audit ~~and CAP~~shall be reported to the ~~CalOptima Compliance~~Audit and Oversight Committee with recommendations for follow-up activities and shared as needed with the Compliance Committee.

   ~~d.~~

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

~~A. CalOptima Contract with the Department of Health Care Services (DHCS)~~
~~B.~~A. ~~CalOptima Contract for Health Care Services~~
~~C. Title 42, United States Code, Sections 1396a(a)(37) and 1396u-2(b)(2)(D)~~
~~D.~~A. ~~Title 28, California Code of Regulations, Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4~~
~~E. Health Insurance Portability and Accountability Act of 1996 (HIPAA)~~
~~F.~~A. California Health and Safety Code, Sections 1371 through 1371.39

B. CalOptima Contract for Health Care Services
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~—~~CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage~~
D.
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. CalOptima Policy HH.2002Δ: Sanctions
H. CalOptima Policy HH.2005Δ: Corrective Action Plan
I. CalOptima Policy HH.5000Δ: Provider Overpayment and Investigation
J. CalOptima Policy MA.9006: Provider Complaint Process
K. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
L. CMS Claims Processing Manual
~~G.~~A. ~~January 21, 2010: All County Information Notice: I-03-10; Subject: CONLAN II Reimbursement Process~~
~~H.~~M. Fee-For-Service and Capitation Claims Audit Performance Standards
~~I.~~N. Financial Reporting Audit Standards
~~J.~~A. ~~CalOptima Policy AA.1000: Glossary of Terms~~
~~K.~~A. ~~CalOptima Policy HH.1101: CalOptima Provider Complaint~~
~~L.~~O. ~~CalOptima Policy HH.2005:~~ Health Network ~~Corrective Action Plan~~Service Agreement
P. January 21, 2010: All County Information Notice: I-03-10; Subject: CONLAN II Reimbursement Process
Q. Title 28, California Code of Regulations-, ~~Sections~~§§ 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4
~~M. CalOptima Policy HH.2002: Sanction~~
~~N. This policy supersedes:~~
R. ~~CalOptima Financial Bulletin #18: Health network fee-for-service claims report~~Title 31, United States Code. ~~Section~~§ 3902(a)
S. Title 42, United States Code, ~~Sections~~§§ 1396a(a)(37), 1396u-2(b)(2)(D) 1816(c)(2) and 1842(c)(2)
T. Title 42, Code of Federal Regulations, ~~Sections~~§§ 422.520(a) and 447.45

~~a.~~

~~VII.~~VI. REGULATORY ~~APPROVALS~~AGENCYAPPROVALS

A. 05/20/16: Department of Health Care Services
B. 12/10/10: Department of Health Care Services
C. 03/31/10: Department of Health Care Services

~~VIII.~~VII. BOARD ~~ACTION~~ACTIONS

A. ~~None to Date~~12/07/17: Regular Meeting of the CalOptima Board of Directors

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	**~~Version~~ Date**	**Policy Number**	**Policy Title**	**Line(s) of Business**
~~Original Date~~Effective	01/01/2007	CC.1101	Health Networks Claims Processing	Medi-Cal
Revised	07/01/2007	FF.2002	Health Networks Claims Processing	Medi-Cal
Revised	01/01/2010	HH.2015	Health Networks Claims Processing	Medi-Cal
Revised	01/01/2011	HH.2015	Health Networks Claims Processing	Medi-Cal
Revised	02/01/2013	HH.2015	Health Networks Claims Processing	Medi-Cal
Revised (Policy Reinstated)	10/01/2015	HH.2015	Health Networks Claims Processing	Medi-Cal
Revised	01/01/2016	HH.2015	Health Networks Claims Processing	Medi-Cal
Revised	12/07/2017	HH.2015	Health Networks Claims Processing	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Clean Claim	A claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under Medi-Cal requirements. A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
Complete Claim	A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: reasonably relevant information and information necessary as defined in Title 28, California Code of Regulations (CCR) section 1300.71 (a)(10) and (a)(11)and as described in 28 CCR sections 1300.71(a)(2)(A)-(F).
Contested Claim	A claim submitted for payment that is considered an incomplete claim submission and that is contested by the health plan as a result of the claim not containing all reasonably relevant information to determine payer liability.
Contracted Provider	A Provider who is obligated by written contract to provide Covered Services to Members.
Coordination of Benefits	A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Covered Services	**Medi-Cal** Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors and funded by CalOptima, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. **OneCare** Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract. **OneCare Connect** Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Denied Claim	A claim for which payment could not be made due to some defect, such as the patient was not a Member, the services were not covered services, the claim was not filed in a timely manner, etc.

Term	Definition
Emergency Medical Condition	A medical condition that is manifested 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: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; and/or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Focused Review	An audit that specifically targets areas of potential deficiency.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia(“PHCs”), Shared Risk Medical Groups (“SRGs”), and Health Maintenance Organizations(“HMOs”).
Member	A beneficiary who is enrolled in a CalOptima program, excluding member of the Program for All Inclusive Care for the Elderly (PACE).
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.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.

Term	Definition
Unclean Claim	A claim from a Provider that does not have all the required data elements, documentation, or information necessary to process the claim or make a final disposition. Unclean claim shall have the same meaning as incomplete claim submission.

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Policy #:	HH.2015
Title:	**Health Networks Claims Processing**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/07
Last Review Date:	12/07/17
Last Revised Date:	12/07/17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy ensures Health Network compliance with claims settlement practices.

II. POLICY

A. A Health Network shall establish and maintain administrative processes, or contract with a claims processing organization, to accept and adjudicate claims for health care services provided to Members, in accordance with the Health Network's contract with CalOptima, as well as the provisions of this policy and applicable laws and regulations.

B. A Health Network shall ensure timely compliance with claims payment obligations and claims settlement practices.

C. A Health Network shall not impose a deadline for the receipt of a claim:

1. Medi-Cal: That is less than ninety (90) calendar days for a participating Provider and one hundred eighty (180) calendar days for a non-participating Provider after the date of service, except as required by state or federal law or regulation.

2. OneCare and OneCare Connect:

   a. For a Non-Contracted provider that is less than twelve (12) months or one (1) calendar year after the date the services were furnished; and

   b. For a Contracted Provider that is less than the time frame specified in the contracted provider agreement. If the contracted provider agreement does not specify a timeframe, the Contracted Provider shall submit a claim within twelve (12) months, or one (1) calendar year after the date the services were furnished.

D. A Health Network shall identify and acknowledge the receipt of each claim, whether or not it is a Complete Claim, and disclose the recorded date of receipt in the same manner as the claim was submitted. Alternatively, the Health Network may provide an electronic means, by telephone, website, or another accessible method of notification, by which the Provider may readily confirm

the Health Network's receipt of the claim and the recorded date of receipt within the time frames specified in Section III.C. of this policy.

E. Claims Processing Timelines

1. Medi-Cal

a. A Health Network shall process and adjudicate ninety percent (90%) of Clean Claims for Covered Services provided to a Member within thirty (30) calendar days after the Health Network's receipt of such Clean Claims.

b. A Health Network shall process and adjudicate one hundred percent (100%) of Contracted and Non-Contracted Clean and Unclean Claims for Covered Services provided to a Member within forty-five (45) calendar days after the Health Network's receipt of such claims.

c. A Health Network shall process and adjudicate ninety-nine percent (99%) of claims for Covered Services provided to a Member within ninety (90) calendar days after the Health Network's receipt of the claim.

d. A Health Network shall notify a Provider of an Unclean Claim for Covered Services provided to a Member within forty-five (45) business days after the Health Network's receipt of the claim. If the Health Network fails to notify the Provider of the Unclean Claim, the Health Network shall consider the claim a Clean Claim and shall pay in accordance with the timelines for Clean Claims as set forth in this policy.

2. OneCare

a. A Health Network shall process and adjudicate ninety-five percent (95%) of Clean Claims for Covered Services provided to a Member within thirty (30) days after the Health Network's receipt of such Clean Claims.

i. For claims not furnished under a written agreement with the submitting provider, a Health Network shall process ninety-nine percent (99%) of Clean Claims for Covered Services provided to a Member within thirty (30) days after the Health Network's receipt of such Clean Claims.

b. All other claims from non-contracted Providers shall be paid or denied within sixty (60) calendar days from the date of the request.

c. A Health Network shall adhere to the Medicare Claims Processing Manual for the handling of all incomplete or invalid claims.

3. OneCare Connect

a. A Health Network shall process and adjudicate ninety-five percent (95%) of claims for Covered Services provided to a Member within thirty (30) calendar days after the Health Network's receipt of such Clean Claims.

b. A Health Network shall process ninety-nine percent (99%) of claims for Covered Services provided to a Member within ninety (90) calendar days from the day of the request of such Clean Claims.

c. A Health Network shall process one hundred percent (100%) of claims from Non-Contracted Providers paid or denied for Covered Services provided to a Member within sixty (60) calendar days from the day of the request of such Unclean claims.

F. Overpayments or adjustments must be identified and written notification sent to Providers of Service within three hundred and sixty-five (365) days of the date the original claim was paid. Providers of service must either contest or pay requested monies within (30) business days of receipt of the notification of overpayment or adjustment pursuant to Health and Safety Code, Section 1371.1. In addition, interest shall accrue at the rate of 10 percent (10%) per annum beginning with the first calendar day after the thirty (30) business day period.

G. A Health Network shall pay interest and applicable penalties.

1. Medi-Cal: For all uncontested claims not paid within forty-five (45) business days, in accordance with Section III.E. of this policy. The interest rate is determined by California Health and Safety Code section 1371 or 1371.35, whichever is applicable.

2. OneCare and OneCare Connect: For all Non-Contracted Claims not paid within thirty (30) calendar days and (60) calendar days for all Contracted Claims after the day of receipt of the claim on a per claim basis, in accordance with Section III.E. of this policy. The interest rate for all Non-Contracted Claims is determined by Title 31 of the United States Code (U.S. Code), Section 3902(a), and Code of Federal Regulations (CFR), Section 422.520 in accordance with Sections 1816(c)(2)(B) and 1842(c)(2)(B) for the period beginning on the thirty-first (31st) day after receipt and ending on the date the Health Network makes payment. The interest rate for all Contracted Claims is determined by the provisions of the contract between the Health Network and the Provider.

H. In the event the Health Network fails to timely and accurately reimburse its claims and the Health Network has not established an approved Corrective Action Plan (CAP) consistent with Health and Safety Code, Section 1375.4(b)(4) and CalOptima Policies HH.2005Δ: Corrective Action Plan, and HH.2002Δ: Sanctions, CalOptima shall take appropriate corrective action, which may include, but is not limited, de-delegation of claims payment.

I. A Health Network shall not improperly deny, adjust, or contest a claim and shall provide a clear and accurate written explanation of the specific reasons for the action taken.

J. A Health Network shall establish and maintain a fair, fast, and cost-effective dispute resolution mechanism to process and resolve Provider disputes that meet the requirements of CalOptima PoliciesHH.1101: Provider Complaint and MA.9006: Provider Complaint Process. A Health Network shall make all records, notes, and documents regarding its Provider dispute resolution mechanism(s) and the resolution of its Provider disputes available to CalOptima and any requesting regulatory agency.

K. A Health Network shall resolve its Provider disputes in a timely manner, including the issuance of a written decision, in accordance with CalOptima Policies HH.1101: Provider Complaint and MA.9006: Provider Complaint Process. CalOptima shall monitor and ensure the administration of

the Health Network's dispute resolution mechanism(s) and for the timely resolution of Provider disputes.

L. A Health Network shall not engage in any practices, policies, or procedures that may constitute a basis for a finding of a demonstrable and unjust payment pattern or unfair payment pattern that results in repeated delays in the adjudication and correct reimbursement of Provider claims.

M. A Health Network shall submit to CalOptima all required claims performance reports within fifteen (15) calendar days after the close of each calendar month or thirty (30) calendar days after the close of each calendar quarter in a format specified by CalOptima. Required reports shall, at a minimum, disclose the Health Network's compliance status with the provisions of this policy, the California Code of Regulations, the Health and Safety Code, Code of Federal Regulations (CFR) and Centers for Medicare & Medicaid Services (CMS) requirements.

N. For OneCare and OneCare Connect: A Health Network shall reimburse a provider for Emergency Services and, if applicable, its affiliated providers for related services at the lowest level of emergency department evaluation and management (Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

III. PROCEDURE

A. Claim Filing Deadlines

1. Medi-Cal: A Health Network shall not impose a deadline for the receipt of a claim that is less than ninety (90) calendar days for a Participating Provider and one hundred and eighty (180) calendar days for a Non-participating Provider after the date of service, except as required by state or federal law or regulation.

2. OneCare and OneCare Connect: For a Non-Contracted provider that is less than twelve (12) months or one (1) calendar year after the date the services were furnished. For a Contracted Provider that is less than the timeframe specified in the contracted provider agreement. If the contracted provider agreement does not specify a timeframe, the Contracted Provider shall submit a claim within twelve (12) months, or one (1) calendar year after the date the services were furnished.

3. If a Health Network denies a claim because it was filed beyond the claim filing deadline, the Health Network shall, upon a Provider's submission of a Provider dispute pursuant to Title 28, California Code of Regulations, Section 1300.71.38,and the demonstration of good cause for the delay, accept and adjudicate the claim in accordance with Health and Safety Code, Sections 1371 or 1371.35, whichever is applicable.

4. If the Health Network is not the primary payer under coordination of benefits, the Health Network shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payer that is less than ninety (90) calendar days from the date of payment or date of contest, denial, or notice from the primary payer.

B. Misdirected Claims

1. For a Provider claim involving Emergency Services or Family Planning Services that is incorrectly sent to a Health Network, the Health Network shall forward the claim to the appropriate Health Network within ten (10) business days after receipt of the claim.

2. For a Provider Claim that does not involve Emergency Services or Family Planning Services that is incorrectly sent to a Health Network, and the Provider that filed the claim is a Contracted Provider, within ten (10) business days of the receipt of the claim the Health Network shall either:

   a. Medi-Cal: Send the Provider a notice of denial, within forty-five (45) business days, with instructions to bill the appropriate Health Network; or

   b. OneCare and OneCare Connect: Send the Provider a notice of denial, within thirty (30) business days for Non-Contracted Claims and (60) business days for Contracted Claims, with instructions to bill the appropriate Health Network; or

   c. Forward the claim to the appropriate Health Network.

3. In all other cases, for claims incorrectly sent to a Health Network, the Health Network shall forward the claim to the appropriate Health Network within ten (10) business days of the receipt of the claim.

4. If a claim is sent to a Health Network and CalOptima is responsible for adjudicating the claim, the Health Network shall forward the claim to CalOptima within ten (10) business days after the receipt of the claim incorrectly sent to the Health Network.

C. Acknowledgment of Claims

1. In the case of an electronic claim, the Health Network shall identify and acknowledge the claim within two (2) business days after the date of receipt of the claim by the office designated to receive claims. Electronic claims received by 5- p.m. on a business day, or by closing time if the Health Network routinely ends its public business day between 4- p.m. and 5- p.m., must be considered as received on that date.

2. In the case of a paper claim, the Health Network shall identify and acknowledge the claim within fifteen (15) business days after the date of receipt of the claim by the office designated to receive claims. Paper claims received by 5- p.m. on a business day, or by closing time if the Health Network routinely ends its public business day between 4 p.m. and 5p.m., must be considered as received on that date. A paper claim received after the routine close of business between 4 p.m. and 5 p.m. is considered received on the next business day.

3. If a Provider submits a claim using a Health Network's claims clearinghouse, the Health Network's identification and acknowledgment to the clearinghouse within the time frames set forth in subparagraph 1 and 2 of this section, whichever is applicable, shall constitute compliance.

D. Interest on Late Claims

1. Medi-Cal

a. Interest shall begin to accrue on the forty-sixth (46th) business day and is calculated based on calendar days.

b. A Health Network shall automatically include, for late payment on a Complete Claim for Emergency Services and care, the greater of fifteen dollars ($15) for each twelve (12) month period or portion thereof on a non-prorated basis, or interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

c. A Health Network shall automatically include, for late payments on all other claims other than Complete Claims for Emergency Services and care, interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

d. If the interest due on an individual claim is less than two dollars ($2), a Health Network may wait until the close of the calendar month and make a lump interest payment for all late claim payments during that time period. The Health Network shall make lump interest payments within ten (10) calendar days of the calendar month's end.

e. If a Health Network fails to automatically include the interest due on a late claim payment, the Health Network shall pay the Provider a ten dollar ($10) penalty for that late claim, in addition to any amounts due.

2. OneCare and OneCare Connect

a. Interest shall begin to accrue on the thirty-first (31st) business day for Non-Contracted Claims, (60) days for Contracted Claims and is calculated based on calendar days. Interest is paid at the rate used for section 3902(a) of Title 3l, U.S. Code and rounded to the nearest penny. The interest rate is determined by the applicable rate on the day of payment. Interest shall be calculated using the following formula:

i. Payment amount x rate x days divided by 365 (366 in a leap year) = interest payment

E. Denying, Adjusting, or Contesting a Claim

1. A Health Network may contest or deny a claim, or portion thereof, by notifying the Provider, in writing, that the claim is contested or denied, within forty-five (45) business days after the date of receipt of the claim by the Health Network for the Medi-Cal program and within thirty (45) business days for Non-Contracted Claims and (60) calendar days for Non-Contracted Claims for OneCare and OneCare Connect.

2. If the Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, the Health Network shall provide a clear, accurate, and written explanation of the necessity for the request. If the Health Network subsequently denies the claim based on the Provider's failure to provide the requested Medical Records or other information, any dispute arising from the denial of such claim shall be handled as a Provider dispute resolution process..

3. If a Health Network fails to provide the Provider with written notice that a claim has been contested or denied within the allowable time period pursuant to Section III.E.1 of this policy, or requests information from the Provider that is not reasonably relevant information and requests information from a third party that is in excess of the information necessary to

determine payer liability, but ultimately pays the claim in whole or in part, the Health Network shall compute the interest or impose a penalty pursuant to Section III.D of this policy.

4. A request for information necessary to determine payer liability from a third party shall not extend the time for reimbursement or the time for contesting or denying claims. The Health Network shall either contest or deny within the time frames set forth in Section III.E.1 of this policy, in writing, incomplete claims and claims for which information necessary to determine payer liability that has been requested, which are held or pended awaiting receipt of additional information. The Health Network shall identify in the denial or contest the individual or entity that was requested to submit information, the specific documents requested and the reason(s) why the information is necessary to determine payer liability.

F. Reimbursement for the Overpayment of Medi-Cal and OneCare Connect Claims

1. If a Health Network determines that it has overpaid a claim, it shall notify the Provider, in writing, through a separate notice clearly identifying the claim, the name of the patient, the date of service and including a clear explanation of the basis upon which the Health Network believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

2. If the Provider contests the Health Network's notice of reimbursement of the overpayment of a claim, the Provider, within thirty (30) business days of the receipt of the notice of overpayment of a claim, shall send written notice to the Health Network stating the basis upon which the Provider believes that the claim was not overpaid. The Health Network shall receive and process the contested notice of overpayment of a claim as a Provider dispute pursuant to Title 28, California Code of Regulations, Section 1300.71.38 and CalOptima Policy HH.1101: CalOptima Provider Complaint and CalOptima Policy MA.9006: Provider Complaint Process, as applicable.

3. If the Provider does not contest the Health Network's notice of reimbursement of the overpayment of a claim, the Provider shall reimburse the Health Network within thirty (30) business days of the receipt by the Provider of the notice of overpayment of a claim.

4. For the Medi-Cal program, if the Provider does not reimburse the Health Network for the overpayment of a claim within thirty (30) business days after receipt of the Health Network's notice, interest shall accrue at the rate of ten percent (10%) per annum beginning with the first (1st) calendar day after the thirty (30) business day period.

5. A Health Network may only offset an uncontested notice of reimbursement of the overpayment of a claim against a Provider's current claim submission when:

   a. The Provider fails to reimburse the Health Network within the timeframe in Section III.F.3 of this policy; and

   b. The Provider has entered into a written contract specifically authorizing the Health Network to offset an uncontested notice of overpayment of a claim from the current claim submissions. In the event that an overpayment of a claim or claims is offset against a Provider's current claim or claims pursuant to this section, the Health Network shall provide the Provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

6. *Conlan* claims and Coordination of Benefits recoveries shall not be considered overpayments under this Policy, and shall be processed in accordance with CalOptima Policy FF.2005: Conlan, Member Reimbursement, and CalOptima Policy FF.2003: Coordination of Benefits, respectively.

G. A Health Network shall provide a Participating Provider upon contracting, annually, and upon the Participating Provider's written request, the following information in a paper or electronic format, which may include a Website containing this information, or another mutually agreeable accessible format:

1. Directions, including the mailing address, email address, and facsimile number, for the electronic transmission (if available), physical delivery, and mailing of claims, all claim submission requirements including a list of commonly required attachments, supplemental information and documentation consistent with reasonably relevant information, instructions for confirming the Health Network's receipt of claims consistent Section III.C of this policy, and a telephone number for claims inquiries and filing information;

2. The identity of the office responsible for receiving and resolving Provider disputes;

3. Directions, including the mailing address, email address, and facsimile number for the electronic transmission (if available), physical delivery, and mailing of Provider disputes and all claim dispute requirements, the timeframe for the Health Network's acknowledgement of the receipt of a Provider dispute and a telephone number for provider dispute inquiries and filing information;

4. Directions for filing substantially similar multiple claims disputes and other billing or contractual disputes in batches as a single Provider dispute that includes a numbering scheme identifying each dispute contained in the bundled case.

5. Complete fee schedule for the Participating Provider consistent with the disclosures specified in Title 28, California Code of Regulations, Section 1300.75.4.1(b); and

6. Detailed payment policies and procedures and rules and non-standard coding methodologies used to adjudicate claims, which shall unless otherwise prohibited by state law:

   a. When available, be consistent with Current Procedural Terminology (CPT) and Medi-Cal or Medicare Coding, the standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies, and major credentialing organizations;

   b. Clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments; and

   c. At a minimum, clearly and accurately state the policies regarding the following:

      i. Consolidation of multiple services or charges and payment adjustments due to coding changes;

ii. Reimbursement for multiple procedures;

iii. Reimbursement for assistant surgeons;

iv. Reimbursement for the administration of immunizations and injectable medications; and

v. Recognition of CPT and Medi-Cal modifiers.

H. A Health Network shall provide a minimum of forty-five (45) days prior written notice before instituting any changes, amendments, or modifications in the disclosures pursuant to Section III.G of this policy.

1. A Health Network, with the agreement of the Participating Provider, may utilize alternate transmission methods to deliver any disclosure required by this policy, as long as the Participating Provider can readily determine and verify that the required disclosures have been transmitted or are accessible and the transmission method complies with all applicable state and federal laws and regulations.

2. The Health Network shall supplement its electronic transmission with paper communication that satisfies the disclosure requirements pursuant to any limitations on the Health Network's ability to electronically transmit any required disclosures as found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended.

I. Managing Claims for Timeliness Compliance

1. A Health Network shall monitor the paid, denied, and pended claims reports daily to ensure that claims are correctly processed and coded, and that the claims meet the timeline requirements.

2. A Health Network shall ensure that timeline reports are completed weekly and shall develop specific action plans to address any deficiencies noted in such reports.

3. A Health Network shall provide the results of any deficiencies noted in a claims audit conducted by the Health Network.

4. A Health Network shall document and maintain action plans related to individual examiners or to the unit as a whole for periodic review by CalOptima or the Health Network.

J. Oversight

1. CalOptima shall conduct a claims audit of a Health Network to ensure the Health Network's compliance with statutory, regulatory, contractual, CalOptima policy and any other requirements related to the CalOptima program.

a. CalOptima shall conduct a readiness assessment of a Health Network prior to the effective date of the Health Network contract.

b. CalOptima shall conduct an annual claims audit of a Health Network.

c. CalOptima may conduct a claims audit of a Health Network that changes its management company.

d. CalOptima may conduct additional claims audits as necessary.

2. Scope of claims audit

a. CalOptima shall, at its discretion, determine the scope and timing of its periodic and regular claims audits.

b. A claims audit may cover one (1) or more functional departments, processes, or delegated functions.

3. Pre-review communications or notice

a. CalOptima may, at its discretion, provide a Health Network with advance notice of a claims audit.

b. If advance notification of a claims audit is given, prior to the date of the review, CalOptima's Office of Compliance Department shall notify a Health Network, in writing, of the following:

i. Date and time of the claims audit;

ii. Areas for review;

iii. Reports and questionnaires that the Health Network shall submit to CalOptima prior to the claims audit; and

iv. Documentation the Health Network shall provide at the time of the claims audit.

c. CalOptima shall make all audit selections from reports submitted by a Health Network and shall return such reports to the Health Network in a timely manner.

4. Claims audit

a. A Health Network shall ensure that the documents are organized in the order of selection provided by CalOptima and accessible on the day of the claims audit. CalOptima may request copies of the documents from the Health Network.

b. A Health Network shall ensure that appropriateness measures include elements pertaining to the validity and accuracy of claims adjudication (payment, denial or contest) and dispute resolution and includes, but is not limited to, accuracy and appropriateness of claims payment, including automatic payment of interest as applicable; validity of denial reasons, documentation and written notification; accuracy, validity and appropriateness of adjustments, including applicability and payment of interest and notifications; mandatory disclosures and notification language for denials, adjusted claims and disputes and other regulatory and contractual requirements; accuracy and appropriateness of notifications, resolution and written determination and other regulatory or contractual requirements as it

pertains to the resolution of disputes; or other measures that may constitute unfair payment practices.

c. If a Health Network and its delegates, subcontractors, and partners are unable to furnish all required documents requested by CalOptima, CalOptima may score missing documents as non-compliant.

d. A Health Network shall make staff available during the claims audit to answer questions and provide necessary information to CalOptima in order to complete the claims audit.

e. For auditing purposes, a Health Network is considered compliant if a Health Network ensures that the requirements of Section II.E of this policy are met. For check cashing, a Health Network shall ensure that at least eighty percent (80%) of checks clear a banking institution within fourteen (14) calendar days after the date the check is mailed. For claims payment timelines, a Health Network shall ensure that the requirements of Section III.E of this policy are met.

6. Report issuance

a. The CalOptima Compliance Department shall provide a Health Network with a post-audit letter containing the audit findings and recommendations within thirty (30) calendar days after the completion of the claims audit.

b. CalOptima shall retain the right to publish data obtained from a Health Network claims audit, and may distribute such data to a Member or to the general public without further notice to or consent from the Health Network.

7. Action based on the Health Network claims audit

a. If CalOptima determines that a Health Network is non-compliant with the provisions of this policy, CalOptima shall conduct a Focused Review within one hundred eighty (180) calendar days after the audit.

b. CalOptima may require a Health Network to submit a CAP addressing all areas of deficiency as determined by CalOptima, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

c. CalOptima may impose remedies such as, but not limited to, de-delegation of claims payment, or may impose sanctions against a Health Network pursuant to CalOptima Policy HH.2002Δ: Sanctions.

d. Findings and CAP(s) from a Health Network's Claims audit shall be reported to the Audit and Oversight Committee with recommendations for follow-up activities and shared as needed with the Compliance Committee.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. California Health and Safety Code, Sections 1371 through 1371.39
B. CalOptima Contract for Health Care Services
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. CalOptima Policy HH.2002Δ: Sanctions
H. CalOptima Policy HH.2005Δ: Corrective Action Plan
I. CalOptima Policy HH.5000Δ: Provider Overpayment and Investigation
J. CalOptima Policy MA.9006: Provider Complaint Process
K. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
L. CMS Claims Processing Manual
M. Fee-For-Service and Capitation Claims Audit Performance Standards
N. Financial Reporting Audit Standards
O. Health Network Service Agreement
P. January 21, 2010: All County Information Notice: I-03-10; Subject: CONLAN II Reimbursement Process
Q. Title 28, California Code of Regulations, §§ 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4
R. Title 31, United States Code. § 3902(a)
S. Title 42, United States Code, §§ 1396a(a)(37), 1396u-2(b)(2)(D) 1816(c)(2) and 1842(c)(2)
T. Title 42, Code of Federal Regulations, §§ 422.520(a) and 447.45

VI. REGULATORY AGENCYAPPROVALS

A. 05/20/16: Department of Health Care Services
B. 12/10/10: Department of Health Care Services
C. 03/31/10: Department of Health Care Services

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2007	CC.1101	Health Networks Claims Processing	Medi-Cal
Revised	07/01/2007	FF.2002	Health Networks Claims Processing	Medi-Cal
Revised	01/01/2010	HH.2015	Health Networks Claims Processing	Medi-Cal
Revised	01/01/2011	HH.2015	Health Networks Claims Processing	Medi-Cal
Revised	02/01/2013	HH.2015	Health Networks Claims Processing	Medi-Cal
Revised (Policy Reinstated)	10/01/2015	HH.2015	Health Networks Claims Processing	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	01/01/2016	HH.2015	Health Networks Claims Processing	Medi-Cal
Revised	12/07/2017	HH.2015	Health Networks Claims Processing	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Clean Claim	A claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under Medi-Cal requirements. A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
Complete Claim	A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: reasonably relevant information and information necessary as defined in Title 28, California Code of Regulations (CCR) section 1300.71 (a)(10) and (a)(11)and as described in 28 CCR sections 1300.71(a)(2)(A)-(F).
Contested Claim	A claim submitted for payment that is considered an incomplete claim submission and that is contested by the health plan as a result of the claim not containing all reasonably relevant information to determine payer liability.
Contracted Provider	A Provider who is obligated by written contract to provide Covered Services to Members.
Coordination of Benefits	A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Covered Services	**Medi-Cal** Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors and funded by CalOptima, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. **OneCare** Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract. **OneCare Connect** Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Denied Claim	A claim for which payment could not be made due to some defect, such as the patient was not a Member, the services were not covered services, the claim was not filed in a timely manner, etc.

Term	Definition
Emergency Medical Condition	A medical condition that is manifested 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: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; and/or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Focused Review	An audit that specifically targets areas of potential deficiency.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia(“PHCs”), Shared Risk Medical Groups (“SRGs”), and Health Maintenance Organizations(“HMOs”).
Member	A beneficiary who is enrolled in a CalOptima program, excluding member of the Program for All Inclusive Care for the Elderly (PACE).
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.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.

Term	Definition
Unclean Claim	A claim from a Provider that does not have all the required data elements, documentation, or information necessary to process the claim or make a final disposition. Unclean claim shall have the same meaning as incomplete claim submission.

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Policy #:	HH.~~2027~~2027Δ
Title:	**Annual Risk Assessment (Delegate)**
Department:	Office of Compliance
Section:	Audit and Oversight
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/14
Last Review Date:	12/~~01/16~~07/17
Last Revised Date:	12/~~01/16~~07/17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy describes the Annual Risk Assessment process conducted by ~~the CalOptima~~CalOptima's Audit & Oversight Department to identify delegated First Tier Entities' (FTE) specific functional areas vulnerable to potential compliance risk. Such areas are documented in CalOptima's risk assessment, which will influence the development of CalOptima's delegated ~~First Tier Entities Audit and Monitoring Work Plan~~FTE's audit and monitoring work plan.

II. POLICY

A. ~~The~~At least annually, the Audit & Oversight Department is responsible for completing a Program Risk Assessment~~, at least annually,~~ to develop its delegated ~~First Tier Entities Audit~~FTE audit and ~~Monitoring Work Plan~~monitoring work plan that ~~provides a comprehensive assessment of~~ensures CalOptima's regulatory obligations~~, including oversight of First Tier, Downstream, and Related Entities (FDRs).~~ are met. In assessing risk, the Audit & Oversight Department shall consider the following:

1. Statutory, regulatory, and contractual standards;
2. ~~CalOptima's~~CalOptima's policies and procedures;
3. ~~-~~Business impact on Member care; and
4. Past compliance issues.

B. The Audit & Oversight Department shall stay current with all regulatory communication and guidance from the Regulatory Agencies.

C. The Audit & Oversight Department shall present annual risk assessment results and the proposed ~~delegated First Tier Entities Audit and Monitoring Work Plan~~FTE audit and monitoring work plan to the Compliance Committee for review and approval by the end of the calendar year to be effective for the following year.

III. PROCEDURE

~~A. The Audit & Oversight Department shall schedule meetings with all operational department leads that provide oversight of delegated First Tier Entities in order to complete the assessment.~~

~~1.~~A. ~~Discovery and Analysis.~~ The Audit & Oversight Department shall undertake a discovery process of the FTEs, consisting of a document review to determine ~~which~~ how regulatory, statutory, ~~regulatory,~~ contractual, and CalOptima policy requirements ~~that~~ are ~~completely~~ implemented; the~~,~~ ~~its~~ operational effectiveness, and how the practices and the documentation support compliance. ~~The discovery process shall consist of document review, an interview process, and review of other relevant information.~~ The analysis component of risk assessment is based on the evaluation of the ~~data from~~FTEs' performance during the ~~business area~~previous calendar year, including but not limited to monthly monitoring results, annual audit and focused reviews when applicable.

~~a. In order to determine whether there are accurate and compliant processes and systems in place,~~ the ~~Audit & Oversight Department shall conduct~~ event that the ~~following activities:~~

~~i.~~1. ~~Delegated~~ First Tier Entity is a new delegate, the Audit & Oversight Department shall audit the First Tier Entity ~~reporting and any other supporting documents such as regulatory communications are evaluated for compliance and receive a risk score that is entered into the Annual Risk Assessment Tool.~~to collect baseline data in accordance with CalOptima Policy GG.1619: Delegation Oversight.

~~ii. Schedule interviews with internal functional area department management and relevant support staff to discuss the compliance level of each delegated First Tier Entity.~~

~~C.~~B. The Audit & Oversight Department shall ~~oversee and review~~consider the following information ~~with the appropriate business units~~ as it applies to ~~activities delegated to First Tier Entities~~FTEs, as part of the risk assessment process:

1. A particular area identified by a Regulatory Agency ~~identifies a particular area~~ as problematic through enforcement actions that may impact CalOptima, including but not limited to, ~~Star Ratings,~~ National Committee on Quality Assurance (NCQA) status~~, and Healthcare Effectiveness Data and Information Set (HEDIS) scores;~~..
2. CalOptima audit findings;
3. Notices of non-compliance;
4. Accuracy of delegate encounter data, submissions, coding, medical loss ratio (MLR) reported data, and other areas that may impact CalOptima payments (e.g., MLR, Hierarchical Condition Category (HCC) risk scores); and
5. Whether there is a Corrective Action Plan (CAP) in effect, and if so, its relative risk for the non-compliance area;

~~D.~~C. ~~Analysis. To validate compliance of the staff interviews, and review other relevant information, the~~The Audit & Oversight Department shall rely on data gathered using the Annual Risk

Assessment ~~Tool~~, and conduct baseline risk assessment audits evaluating file reviews, data collected from annual audit results, and number of CAPs issued during the review period.

1. ~~As data-driven analysis is significant to determine functional area risk to Members, the~~The Audit & Oversight Department shall compile the data~~, using the scoring methodology for the risk assessment tool~~ and ~~then~~ rank the risks based on the greatest impact on delegated operations and quality health care delivery to CalOptima Members.

~~E. The Audit & Oversight Department shall prioritize those with greatest risk when developing the annual Audit and Monitoring Work Plan.~~

~~F.~~D. The Audit & Oversight Department shall present the ~~delegated First Tier Entity~~FTE risk assessment results and proposed Audit and ~~Monitoring Work Plan~~Oversight work plan to the Audit & Oversight Committee (AOC) ~~for a recommendation~~and subsequently to ~~be presented for approval by~~ the Compliance Committee for approval.

~~G.~~E. The Audit & Oversight Department shall re-evaluate the ~~risk~~work plan based on internal changes for approval (e.g., staffing and organizational structure changes, audit results, monitoring results, etc.) and external changes (e.g., regulatory changes, marketplace changes, Regulatory Agency audit results~~).~~, etc.).

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract for Health Care Services
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
F. Health Network Service Agreement
G. Prescription Drug Benefit Manual Chapter 9 - Compliance Program Guidelines
H. Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines
I. Title 42, Code of Federal Regulations (C.F.R.), §455.2
J. Welfare and Institutions Code. §14043.1(a)
~~J.~~K. CalOptima Policy GG.1619: Delegation Oversight

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors

~~A.~~B. 12/01/16:~~–~~ Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	11/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	09/01/2015	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE
Effective	09/01/2015	HH.2027	Annual Risk Assessment	Medi-Cal
Revised	12/01/2016	HH.2027	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2027Δ	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Annual Risk Assessment Tool	A tool utilized to stratify (high, medium, low) audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	That committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox Keene Health Care Service Plan Act of 1975, Health & Safety Code, Sections 1340 *et seq.*
Downstream Entity	Any party that enters into a written arrangement acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
~~First Tier, Downstream, and Related Entities (FDR)~~	~~FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.~~
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima program.

Term	Definition
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)
Member	A beneficiary who is enrolled in a CalOptima Program.
Regulatory Agencies	For the purposes of this policy regulatory agencies include Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG) and Office of Civil Rights (OCR).
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period~~.~~.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy #:	HH.2027Δ
Title:	**Annual Risk Assessment (Delegate)**
Department:	Office of Compliance
Section:	Audit and Oversight
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/14
Last Review Date:	12/07/17
Last Revised Date:	12/07/17

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

I. PURPOSE

This policy describes the Annual Risk Assessment process conducted by CalOptima's Audit & Oversight Department to identify delegated First Tier Entities' (FTE) specific functional areas vulnerable to potential compliance risk. Such areas are documented in CalOptima's risk assessment, which will influence the development of CalOptima's delegated FTE's audit and monitoring work plan.

II. POLICY

A. At least annually, the Audit & Oversight Department is responsible for completing a Program Risk Assessment to develop its delegated FTE audit and monitoring work plan that ensures CalOptima's regulatory obligations are met. In assessing risk, the Audit & Oversight Department shall consider the following:

1. Statutory, regulatory, and contractual standards;
2. CalOptima's policies and procedures;
3. Business impact on Member care; and
4. Past compliance issues.

B. The Audit & Oversight Department shall stay current with all regulatory communication and guidance from the Regulatory Agencies.

C. The Audit & Oversight Department shall present annual risk assessment results and the proposed FTE audit and monitoring work plan to the Compliance Committee for review and approval by the end of the calendar year to be effective for the following year.

III. PROCEDURE

A. The Audit & Oversight Department shall undertake a discovery process of the FTEs, consisting of a document review to determine how regulatory, statutory, contractual, and CalOptima policy requirements are implemented; the operational effectiveness, and how the practices and the

documentation support compliance. The analysis component of risk assessment is based on the evaluation of the FTEs' performance during the previous calendar year, including but not limited to monthly monitoring results, annual audit and focused reviews when applicable.

1. In the event that the First Tier Entity is a new delegate, the Audit & Oversight Department shall audit the First Tier Entity to collect baseline data in accordance with CalOptima Policy GG.1619: Delegation Oversight.

B. The Audit & Oversight Department shall consider the following information as it applies to FTEs, as part of the risk assessment process:

1. A particular area identified by a Regulatory Agency as problematic through enforcement actions that may impact CalOptima, including but not limited to, National Committee on Quality Assurance (NCQA) status.

2. CalOptima audit findings;

3. Notices of non-compliance;

4. Accuracy of delegate encounter data, submissions, coding, medical loss ratio (MLR) reported data, and other areas that may impact CalOptima payments (e.g., MLR, Hierarchical Condition Category (HCC) risk scores); and

5. Whether there is a Corrective Action Plan (CAP) in effect, and if so, its relative risk for the non-compliance area;

C. The Audit & Oversight Department shall rely on data gathered using the Annual Risk Assessment, and conduct baseline risk assessment audits evaluating file reviews, data collected from annual audit results, and number of CAPs issued during the review period.

1. The Audit & Oversight Department shall compile the data and rank the risks based on the greatest impact on delegated operations and quality health care delivery to CalOptima Members.

D. The Audit & Oversight Department shall present the FTE risk assessment results and proposed Audit and Oversight work plan to the Audit & Oversight Committee (AOC) and subsequently to the Compliance Committee for approval.

E. The Audit & Oversight Department shall re-evaluate the work plan based on internal changes for approval (e.g., staffing and organizational structure changes, audit results, monitoring results, etc.) and external changes (e.g., regulatory changes, marketplace changes, Regulatory Agency audit results, etc.).

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan

B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract for Health Care Services
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
F. Health Network Service Agreement
G. Prescription Drug Benefit Manual Chapter 9 - Compliance Program Guidelines
H. Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines
I. Title 42, Code of Federal Regulations (C.F.R.), §455.2
J. Welfare and Institutions Code. §14043.1(a)
K. CalOptima Policy GG.1619: Delegation Oversight

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
B. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	11/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	09/01/2015	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE
Effective	09/01/2015	HH.2027	Annual Risk Assessment	Medi-Cal
Revised	12/01/2016	HH.2027	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2027Δ	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Annual Risk Assessment Tool	A tool utilized to stratify (high, medium, low) audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	That committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox Keene Health Care Service Plan Act of 1975, Health & Safety Code, Sections 1340 *et seq.*
Downstream Entity	Any party that enters into a written arrangement acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)
Member	A beneficiary who is enrolled in a CalOptima program.

Term	Definition
Regulatory Agencies	For the purposes of this policy regulatory agencies include Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG) and Office of Civil Rights (OCR).
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy #:	HH.3000Δ
Title:	**Notice of Privacy Practices**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	~~03/01~~12/07/17
Last Revised Date:	12/~~01/16~~07/17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy identifies the required content of CalOptima's Notice of Privacy Practices (NPP) and the process by which the NPP is distributed to CalOptima Members.

II. POLICY

A. CalOptima Members have the right to adequate notice of the Uses and Disclosures of Protected Health Information (PHI) that may be made by CalOptima and of the Members' rights and CalOptima's legal duties with respect to PHI.

B. CalOptima ~~provides~~shall provide information that directs Members on the process to file complaints with CalOptima and its regulators and will not retaliate against Members who file complaints when they believe their privacy rights have been violated, in accordance with CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations.

C. CalOptima ~~provides~~shall provide the NPP to Members as required by law, including~~,~~ providing the NPP upon enrollment and providing notice upon material revisions of the NPP on its website.

III. PROCEDURE

A. The content of the NPP shall be written in plain language~~,~~ and contain the following elements:

1. Mandated header;

2. Description and one (1) example each, of the types of Use and Disclosures that CalOptima is permitted under state and federal regulations for the purposes of Treatment, Payment, and Health Care Operations. ~~-~~If a Use or Disclosure for any purpose described in paragraphs (b)(1)(ii)(A) or (B) of Title 45, Code of Federal Regulations, Section 164.520 is prohibited or materially limited by other applicable law, the description of such Use or Disclosure must reflect the more stringent law as defined in Title 45, Code of Federal Regulations, Section 160.202;

3. A description of the types of Uses and Disclosures that requires an authorization under Section 164.504(a)(2)-(a)(4), a statement that other Use and Disclosures not described in this notice will

be made only with the Member's written authorization, and a statement that the Member may revoke such authorization as provided by Section 164.508(b)(5);

4. Statement to describe the Member's rights concerning his or her PHI, how to exercise these rights, and restrictions on such rights, ~~that~~which shall include information on:

   a. Restrictions concerning certain Use and Disclosures of PHI, and provision that CalOptima is not required to agree to those restrictions, except in case of a Disclosure restricted under Section 164.522(a)(1)(iv) and in accordance with CalOptima Policy HH.3007Δ: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information;

   b. Right to receive confidential communications of PHI, in accordance with CalOptima Policy HH.3008Δ: Member Right to Request Confidential Communications;

   c. Right to inspect and copy PHI, in accordance with CalOptima Policy HH.3001Δ: Member Access to Designated Record Set;

   d. Right to request amendment to PHI, in accordance with CalOptima Policy HH.3004Δ: Member Request to Amend Record;

   e. Right to receive accounting of Disclosures, with certain exceptions, in accordance with CalOptima Policy HH.3005Δ: Member Request for an Accounting of Disclosures; and

   f. Right to receive a paper copy of the NPP, in accordance with this policy.

5. Statement specifically describing CalOptima's duties and rights under the privacy rule, including:

   ~~a.~~ A statement that CalOptima is required by law to maintain the privacy of the Member's PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to notify affected Members following a breach of unsecured PHI, and in accordance with CalOptima policies, which shall include processes to ensure internal protection of~~:~~

   ~~i.~~a. ~~Verbal~~ verbal (i.e., when talking to individuals on the telephone or in person about a Member), and written information, in accordance with CalOptima Policies HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information, HH.3009Δ: Access by Member's Authorized Representative, HH.3016Δ: Guidelines for Handling Protected Health Information Offsite, and HH.3019Δ: De-identification of Protected Health Information.

   b. The responsibility to abide by the terms of the NPP currently in effect;

   c. Reserve our right to make changes to the terms of the NPP when we make changes to our privacy practices; and

   d. A description of how CalOptima provides Members with a revised NPP.

6. Statement that the Member may file a complaint as part of their privacy rights, and without retaliation, to CalOptima's Customer Service Department~~,~~ or Privacy Officer, the California

Department of Health Care Services (DHCS), and/or the United States Department of Health and Human Services (HHS), if the Member believes his or her privacy rights have been violated, and include contact title and telephone number for filing the complaint with CalOptima, or to get further information concerning the notice. The contact information should include:

a. Privacy Officer
CalOptima
505 City Parkway West
Orange, CA 92868
Telephone: ~~(~~1-888~~) -~~587-8088;

b. CalOptima Customer Service Department
Telephone: ~~(~~1-714~~) -~~246-8500
Toll-free: ~~(~~1-888~~) -~~587-8088
TDD/TTY: ~~(~~1-800~~) -~~735-2929;

c. Privacy Officer
c/o: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Telephone: ~~(~~1-916~~) -~~445-4646
Fax: ~~(~~1-916~~) -~~440-7680; and

d. Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
~~Voice~~ Phone ~~(~~: 1-800~~) -~~368-1019
~~FAX (~~Fax: 1-415~~) -~~437-8329
TDD ~~(~~: 1-800~~) -~~537-7697
Email: OCRComplaint@hhs.gov

7. Effective date of the notice.

B. The NPP shall be made available to anyone, upon request, by calling~~,~~ or writing~~,~~ to the CalOptima Customer Service Department. CalOptima's Customer Service Department shall make the NPP available in Threshold Languages to anyone by mail, in person, or through the CalOptima website. CalOptima shall distribute the NPP by:

1. Ensuring initial distribution by mail to all Members, prior to April 2003;

2. Including copies in all new enrollment packets, effective April 2003;

3. Posting a copy in the Customer Service Department lobby in Threshold languages;

4. Posting the NPP on the CalOptima website;

a. Upon a material change to the NPP, CalOptima shall prominently post the change, or the revised NPP, on the CalOptima website by the effective date of the material change to the notice.

5. Providing a revised NPP, or information about the material change and how to obtain the revised NPP, in the next annual mailing to Members; and

6. Notifying all Members at least once every three (3) years that a copy of the NPP is available upon request, or may be obtained on the CalOptima website at www.caloptima.org.

7. CalOptima shall include with all mailings of the NPP:

a. A statement of non-discrimination acknowledging that CalOptima complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex; and

b. Taglines informing Members of the availability of language assistance services.

C. Documentation and Retention:

1. CalOptima shall document compliance with this policy, and retain copies of the notices issued for a period of ten (10) years from the effective date of the notice.

IV. ATTACHMENTS

A. Notice of Privacy Practices ~~(Medi-Cal)~~
B. Notice of ~~Privacy Practices (Medicare~~Non-Discrimination and Language Taglines (Medi-Cal)
C. Notice of Non-Discrimination and Language Taglines (OC)
D. Notice of Non-Discrimination and Language Taglines (OCC)
E. Language Assistance Taglines (Medi-Cal)
F. Language Assistance Taglines (OC)
~~B.~~G. Language Assistance Taglines (OCC)

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
~~E. CalOptima Policy AA.1000: Glossary of Terms~~
~~F. CalOptima Policy CMC.1001: Glossary of Terms~~
~~G. CalOptima Policy MA.1001: Glossary of Terms~~
~~H.~~E. CalOptima Policy GA.5005a: Use of Technology Resources
~~I.~~F. CalOptima Policy GA.5005b: Email and Internet Use
~~J.~~G. CalOptima Policy GA.5005c: Laptop Loaner
~~K.~~H. CalOptima Policy HH.3001Δ: Member Access to Designated Record Set
~~L.~~I. CalOptima Policy HH.3012Δ: Non-Retaliation on Reporting Violations

~~M.~~J. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information
~~N.~~K. CalOptima Policy HH.3004Δ: Member Request to Amend Record
~~O.~~L. CalOptima Policy HH.3005Δ: Member Request for an Accounting of Disclosures
~~P.~~M. CalOptima Policy HH.3007Δ: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information
~~Q.~~N. CalOptima Policy HH.3008Δ: Member Right to Request Confidential Communications
~~R.~~O. CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative
~~S.~~P. CalOptima Policy HH.3014Δ: Use of Electronic Mail with Protected Health Information
~~T.~~Q. CalOptima Policy HH.3016Δ: Guidelines for Handling Protected Health Information Offsite
~~U.~~R. CalOptima Policy HH.3019Δ: De-identification of Protected Health Information
~~V.~~S. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~W.~~T. MMCD All Plan Letter ~~06001~~06-001: Notice of Privacy Practices and Notification of Breaches
U. MMCD All Plan Letter 17-011: Standards For Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act
~~X.~~V. NCQA Standard MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 1-2017
~~Y.~~W. Title 45, Code of Federal Regulations (C.F.R.), §164.105(c)(2)
~~Z.~~X. Title 45, Code of Federal Regulations (C.F.R.), §164.520
~~AA.~~Y. Title 45, Code of Federal Regulations (C.F.R.), §164.530(g)
Z. Patient Protection and Affordable Care Act §1557

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. ~~-~~BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/01/16: ~~–~~ Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3000	Notice of Privacy Practices	Medi-Cal
Effective	06/01/2005	MA.9202	Notice of Privacy Practices	OneCare
Revised	07/01/2007	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	02/01/2008	MA.9202	Notice of Privacy Practices	OneCare
Revised	04/01/2009	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2011	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2013	HH.3000Δ	Notice of Privacy Practices	Medi-Cal OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	01/01/2014	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	05/01/2014	MA.9202	Notice of Privacy Practices	OneCare
Revised	11/01/2014	MA.9202	Notice of Privacy Practices	OneCare
Revised	09/01/2015	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	09/01/2015	MA.9202	Notice of Privacy Practices	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3000Δ	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9202	Notice of Privacy Practices	OneCare OneCare Connect PACE
Reviewed	03/01/2017	HH.3000Δ	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3000Δ	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Maintenance Organization	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.
Member	An enrollee-beneficiary of a CalOptima program.
Notice of Privacy Practices (NPP)	Notice provided to a Member that describes Cal Optima's practices in the Use and Disclosure of Protected Health Information, Member rights, and CalOptima legal duties with respect to Protected Health Information.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	Definition
Required by Law	Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.
Threshold Languages	Medi-Cal: Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA). OneCare, OneCare Connect, PACE: The non-English native language of a group served by the CMS Program as specified in annual guidance to Contractors on specific translation requirements for their service areas.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

Policy #:	HH.3000Δ
Title:	**Notice of Privacy Practices**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
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Last Revised Date:	12/07/17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

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1. Mandated header;

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3. A description of the types of Uses and Disclosures that requires an authorization under Section 164.504(a)(2)-(a)(4), a statement that other Use and Disclosures not described in this notice will

be made only with the Member's written authorization, and a statement that the Member may revoke such authorization as provided by Section 164.508(b)(5);

4. Statement to describe the Member's rights concerning his or her PHI, how to exercise these rights, and restrictions on such rights, which shall include information on:

   a. Restrictions concerning certain Use and Disclosures of PHI, and provision that CalOptima is not required to agree to those restrictions, except in case of a Disclosure restricted under Section 164.522(a)(1)(iv) and in accordance with CalOptima Policy HH.3007Δ: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information;

   b. Right to receive confidential communications of PHI, in accordance with CalOptima Policy HH.3008Δ: Member Right to Request Confidential Communications;

   c. Right to inspect and copy PHI, in accordance with CalOptima Policy HH.3001Δ: Member Access to Designated Record Set;

   d. Right to request amendment to PHI, in accordance with CalOptima Policy HH.3004Δ: Member Request to Amend Record;

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   b. The responsibility to abide by the terms of the NPP currently in effect;

   c. Reserve our right to make changes to the terms of the NPP when we make changes to our privacy practices; and

   d. A description of how CalOptima provides Members with a revised NPP.

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violated, and include contact title and telephone number for filing the complaint with CalOptima, or to get further information concerning the notice. The contact information should include:

a. Privacy Officer
CalOptima
505 City Parkway West
Orange, CA 92868
Telephone: 1-888-587-8088;

b. CalOptima Customer Service Department
Telephone: 1-714-246-8500
Toll-free: 1-888-587-8088
TDD/TTY: 1-800-735-2929;

c. Privacy Officer
c/o: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Telephone: 1-916-445-4646
Fax: 1-916-440-7680; and

d. Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: 1-800-368-1019
Fax: 1-415-437-8329
TDD: 1-800-537-7697
Email: OCRComplaint@hhs.gov

7. Effective date of the notice.

B. The NPP shall be made available to anyone, upon request, by calling or writing to the CalOptima Customer Service Department. CalOptima's Customer Service Department shall make the NPP available in Threshold Languages to anyone by mail, in person, or through the CalOptima website. CalOptima shall distribute the NPP by:

1. Ensuring initial distribution by mail to all Members, prior to April 2003;

2. Including copies in all new enrollment packets, effective April 2003;

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a. Upon a material change to the NPP, CalOptima shall prominently post the change, or the revised NPP, on the CalOptima website by the effective date of the material change to the notice.

5. Providing a revised NPP, or information about the material change and how to obtain the revised NPP, in the next annual mailing to Members; and

6. Notifying all Members at least once every three (3) years that a copy of the NPP is available upon request, or may be obtained on the CalOptima website at www.caloptima.org.

7. CalOptima shall include with all mailings of the NPP:

a. A statement of non-discrimination acknowledging that CalOptima complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex; and

b. Taglines informing Members of the availability of language assistance services.

C. Documentation and Retention:

1. CalOptima shall document compliance with this policy, and retain copies of the notices issued for a period of ten (10) years from the effective date of the notice.

IV. ATTACHMENTS

A. Notice of Privacy Practices
B. Notice of Non-Discrimination and Language Taglines (Medi-Cal)
C. Notice of Non-Discrimination and Language Taglines (OC)
D. Notice of Non-Discrimination and Language Taglines (OCC)
E. Language Assistance Taglines (Medi-Cal)
F. Language Assistance Taglines (OC)
G. Language Assistance Taglines (OCC)

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
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D. CalOptima PACE Program Agreement
E. CalOptima Policy GA.5005a: Use of Technology Resources
F. CalOptima Policy GA.5005b: Email and Internet Use
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T. MMCD All Plan Letter 06-001: Notice of Privacy Practices and Notification of Breaches
U. MMCD All Plan Letter 17-011: Standards For Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act
V. NCQA Standard MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 1-2017
W. Title 45, Code of Federal Regulations (C.F.R.), §164.105(c)(2)
X. Title 45, Code of Federal Regulations (C.F.R.), §164.520
Y. Title 45, Code of Federal Regulations (C.F.R.), §164.530(g)
Z. Patient Protection and Affordable Care Act §1557

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
B. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3000	Notice of Privacy Practices	Medi-Cal
Effective	06/01/2005	MA.9202	Notice of Privacy Practices	OneCare
Revised	07/01/2007	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	02/01/2008	MA.9202	Notice of Privacy Practices	OneCare
Revised	04/01/2009	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2011	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2013	HH.3000Δ	Notice of Privacy Practices	Medi-Cal OneCare
Revised	01/01/2014	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	05/01/2014	MA.9202	Notice of Privacy Practices	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	11/01/2014	MA.9202	Notice of Privacy Practices	OneCare
Revised	09/01/2015	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	09/01/2015	MA.9202	Notice of Privacy Practices	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3000Δ	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9202	Notice of Privacy Practices	OneCare OneCare Connect PACE
Reviewed	03/01/2017	HH.3000Δ	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3000Δ	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Maintenance Organization	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.
Member	An enrollee-beneficiary of a CalOptima program.
Notice of Privacy Practices (NPP)	Notice provided to a Member that describes Cal Optima's practices in the Use and Disclosure of Protected Health Information, Member rights, and CalOptima legal duties with respect to Protected Health Information.
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Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	Definition
Required by Law	Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.
Threshold Languages	Medi-Cal: Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA). OneCare, OneCare Connect, PACE: The non-English native language of a group served by the CMS Program as specified in annual guidance to Contractors on specific translation requirements for their service areas.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Notice of Privacy Practices

Effective: April 14, 2003 | Updated: December 2016

CalOptima provides you access to health care through the Medicare and/or Medi-Cal program. We are required by state and federal law to protect your health information. After you become eligible and enroll in our health plan, Medicare and/or Medi-Cal sends your information to us. We also receive medical information from your doctors, clinics, labs and hospitals in order to approve and pay for your health care.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. You must make this request in writing. You will be sent a form to fill out and we may charge a reasonable fee for the costs of copying and mailing records. You must provide a valid form of identification in order to view or get a copy of your health records. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. • We may keep you from seeing certain parts of your records for reasons allowed by law. • **CalOptima does not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.**
Ask us to correct health and claims records	• You have the right to send in a written request to ask that information in your records be changed if it is not correct or complete. You must make your request in writing. • We may refuse your request if the information is not created or kept by CalOptima, or we believe it is correct and complete but we'll tell you why in writing within 60 days. • If we don't make the changes you ask, you may ask that we review our decision. You may also send a statement saying why you disagree with our records, and your statement will be kept with your records.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask. • You have the right to request a list (accounting) of what information was shared, who it was shared with, when it was shared and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. • You can also find this notice on our website at www.caloptima.org.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information in this notice. • We will not retaliate against you for filing a complaint.
Self-pay restriction	• If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us. If you or your provider submits a claim to CalOptima, we do not have to agree to a restriction. If a law requires the disclosure, CalOptima does not have to agree to your restriction.

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, please contact us. In most cases, if we use or disclose your PHI outside of treatment, payment or operations, we must get your **written** permission first. If you give us your permission, you may take it back in writing at any time. We can't take back what we used or shared when we had your written permission, but we will stop using or sharing your PHI in the future.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation

In these cases we *never* share your information unless you give us written permission:	• Psychotherapy Notes: We must obtain your authorization for any use or disclosure of psychotherapy notes except to carry out certain treatment, payment or health care operations. • Marketing purposes • Sale of your information

Our Uses and Disclosures

Your information may be used or shared by CalOptima only for a reason directly connected to Medicare and/or Medi-Cal program. The information we use and share includes, but is not limited to:

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.**	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information with the doctors, clinics and others who bill us for your care. We may also forward bills to other health plans or organizations for payment.*
Administer your plan	• We may disclose your health information to the Department of Healthcare Services (DHCS) and/ or the Centers for Medicare & Medicaid Services (CMS) for plan administration.	***Example:*** *DHCS contracts with us to provide a health plan, and we provide DHCS with certain statistics.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Comply with special laws	• There are special laws that protect some types of health information such as mental health services, treatment for substance use disorders, and HIV/AIDS testing and treatment. We will obey these laws when they are stricter than this notice. • There are also laws that limit our use and disclosure to reasons directly connected to the administration of CalOptima's healthcare programs.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Notice of Privacy Practices

Changes to the Terms of This Notice

CalOptima reserves the right to change its privacy notice and the ways we keep your PHI safe. If that happens, we will update the notice and notify you. We will also post the updated notice on our website.

How to Contact us to Use Your Rights

If you want to use any of the privacy rights explained in this notice, please write us at:

Privacy Officer
CalOptima
505 City Parkway West
Orange, CA 92868
1-888-587-8088

Or call CalOptima's Customer Service Department at: **1-714-246-8500**

Toll-free at **1-888-587-8088**
TDD/TTY: **1-800-735-2929**

If you believe that we have not protected your privacy and wish to file a complaint or grievance, you may write or call CalOptima at the address and phone number above. You may also contact the agencies below:

California Department of Health Care Services
Privacy Officer
C/O: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Phone: 1-916-445-4646
Fax: 1-916-440-7680

U.S. Dept. of Health and Human Services
Office for Civil Rights
Regional Manager
90 7th Street, Suite 4-100
San Francisco, CA 94103
Email: OCRComplaint@hhs.gov
Phone: 1-800-368-1019
Fax: 1-415-437-8329
TDD: 1-800-537-7697

Use Your Rights Without Fear

CalOptima cannot take away your health care benefits nor do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this notice.

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Notice of Privacy Practices

This notice applies to all of CalOptima's health care programs.

NONDISCRIMINATION NOTICE

Discrimination is against the law. CalOptima follows Federal civil rights laws. CalOptima does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

CalOptima provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact CalOptima at **1-714-246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. Or, if you cannot hear or speak well, please call TTY/TDD at **1-800-735-2929**.

HOW TO FILE A GRIEVANCE

If you believe that CalOptima has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with CalOptima. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact CalOptima between 8 a.m. and 5:30 p.m. by calling toll-free at **1-888-587-8088**. Or, if you cannot hear or speak well, please call TTY/TDD at **1-800-735-2929**.
- In writing: Fill out a complaint form or write a letter and send it to:

  CalOptima Grievance and Appeals
  505 City Parkway West
  Orange, CA 92868

- In person: Visit your doctor's office or CalOptima and say you want to file a grievance.
- Electronically: Visit CalOptima's website at **www.caloptima.org**.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call TTY/TDD **1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

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Language Assistance

English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call **1-888-587-8088** (TTY: **1-800-735-2929**).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-587-8088** (TTY: **1-800-735-2929**).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-587-8088** (TTY: **1-800-735-2929**).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-587-8088** (TTY: **1-800-735-2929**).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-587-8088** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-587-8088**（TTY：**1-800-735-2929**）。

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-888-587-8088** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-587-8088** (телетайп: **1-800-735-2929**).

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فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-888-587-8088** (TTY: **1-800-735-2929**) تماس بگیرید.

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけ
す。**1-888-587-8088**（TTY: **1-800-735-2929**）まで、お電話にてご連絡ください。

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-888-587-8088** (TTY: **1-800-735-2929**).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-888-587-8088** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-587-8088** (رقم هاتف الصم والبكم: **1-800-735-2929**).

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-888-587-8088** (TTY: **1-800-735-2929**) पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-888-587-8088** (TTY: **1-800-735-2929**).

ខ្មែរ (Cambodian)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-888-587-8088** (TTY: **1-800-735-2929**)។

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-888-587-8088** (TTY: **1-800-735-2929**).

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OneCare (HMO SNP)
CalOptima
A Public Agency
Better. Together.

Notice of Nondiscrimination

OneCare (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. OneCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

OneCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact OneCare Customer Service at **1-877-412-2734**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**. If you believe that OneCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance & Appeals Resolution Services
505 City Parkway West, Orange, CA 92868
Telephone number: 1-714-246-8554
TTY number: 1-800-735-2929
Fax: 1-714-246-8562
Email: grievancemailbox@caloptima.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Grievance & Appeals Resolution Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract and a contract with the California Medi-Cal (Medicaid) program. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-877-412-2734**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-412-2734** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-412-2734** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-412-2734** (TTY: **1-800-735-2929**).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-412-2734** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-412-2734** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-412-2734** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-877-412-2734** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-877-412-2734** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-412-2734** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 **1-877-412-2734** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

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Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم **1-877-412-2734** (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-877-412-2734** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।.

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-877-412-2734** (TTY: **1-800-735-2929**).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-877-412-2734** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-412-2734** (TTY: **1-800-735-2929**) पर कॉल करें।.

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-877-412-2734** (TTY: **1-800-735-2929**).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-877-412-2734 (**TTY: **1-800-735-2929)**.

OneCare Connect
CalOptima
A Public Agency
Better. Together.

Notice of Nondiscrimination

OneCare Connect Cal MediConnect Plan (Medicare- Medicaid Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. OneCare Connect does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

OneCare Connect:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact OneCare Connect Customer Service at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**. If you believe that OneCare Connect has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance & Appeals Resolution Services
505 City Parkway West, Orange, CA 92868
Telephone number: 1-714-246-8554
TTY number: 1-800-735-2929
Fax: 1-714-246-8562
Email: grievancemailbox@caloptima.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Grievance & Appeals Resolution Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

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Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

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Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**).

Back to Agenda

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

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Arabic:
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Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

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NONDISCRIMINATION NOTICE

Discrimination is against the law. CalOptima follows Federal civil rights laws. CalOptima does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

CalOptima provides:

- Free aids and services to people with disabilities to help them communicate better, such as:

  ✓ Qualified sign language interpreters
  ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:

  ✓ Qualified interpreters
  ✓ Information written in other languages

If you need these services, contact CalOptima at **1-714- 246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. Or, if you cannot hear or speak well, please call TTY/TDD at **1-800-735-2929**.

HOW TO FILE A GRIEVANCE

If you believe that CalOptima has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with CalOptima. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact CalOptima between 8 a.m. and 5:30 p.m. by calling toll-free at 1-888-587-8088. Or, if you cannot hear or speak well, please call TTY/TDD at 1-800-735-2929.

- In writing: Fill out a complaint form or write a letter and send it to:

  CalOptima Grievance and Appeals
  505 City Parkway West
  Orange, CA 92868

- In person: Visit your doctor's office or CalOptima and say you want to file a grievance.

- Electronically: Visit CalOptima's website at **www.caloptima.org**.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

"LANGUAGE ASSISTANCE"

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-587-8088 (TTY: 1-800-735-2929).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-587-8088 (TTY: 1-800-735-2929).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-587-8088 (TTY: 1-800-735-2929).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-587-8088 (TTY: 1-800-735-2929).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니. 다. 1-888-587-8088 (TTY: 1-800-735-2929)번으로 전화해 주십시오.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-587-8088（TTY：1- 800-735-2929）。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-888-587-8088 (TTY (հեռատիպ)՝ 1-800-735-2929):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-587-8088 (телетайп: 1-800-735-2929).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-587-8088 (TTY 1-800-735-2929: تماس بگیرید.)

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-888-587- 8088（TTY: 1-800-735-2929）まで、お電話にてご連絡ください。

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus *Hmoob*, cov kev pab txog lus, muaj kev pab dawb rau koj.
Hu rau 1-888-587-8088 (TTY: 1-800-735-2929).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।

1-888- 587-8088 (TTY: 1-800-735-2929) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-587-8088
(رقم هاتف الصم والبكم: 1-800-735-2929).

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मु त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-587-8088
(TTY: 1-800-735-2929) पर कॉल करें।

ภาษาไทย (Thai)

ธียน: ถ้ าคุณพูดภาษาไทยคุณสามารถใช้ บริการช่ วยเหลือทางภาษาได้ ฟรี โทร 1-888-587-8088
(TTY: 1-800-735-2929).

ខ្មែរ (Cambodian)

របយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយែផ្នកភាសា ដោយមិនគិតឈ្ន ួល គឺអាចមានសំរាប់បំរើអ្នក។ ជួ ទូរស័ព្ទ
1-888-587-8088 (TTY: 1-800-735-2929)។

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້ າວ່ ່ າ ທ່ ານເວ ້ົ ້ າພາສາ ລາວ, ການບ ລິ ການຊ ່ ວຍເຫ ຼ ືອ ດ ້ ານພາສາ, ໂດຍບ ່ ສ ຽ ສ ່ ຳ,
ແມ ນມ ພ ອ ມ ໃ ຫ ້ ທ ານ ໂທ ຣ 1-888-587-8088 (TTY: 1-800-735-2929).

Notice of Nondiscrimination

OneCare (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. OneCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

OneCare:

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U.S. Department of Health and Human Services
200 Independence Avenue, SW

Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract and a contract with the California Medi-Cal (Medicaid) program. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-877-412-2734**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

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Notice of Nondiscrimination

OneCare Connect Cal MediConnect Plan (Medicare- Medicaid Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. OneCare Connect does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

OneCare Connect:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact OneCare Connect Customer Service at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**. If you believe that OneCare Connect has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance & Appeals Resolution Services
505 City Parkway West, Orange, CA 92868
Telephone number: 1-714-246-8554
TTY number: 1-800-735-2929
Fax: 1-714-246-8562
Email: grievancemailbox@caloptima.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Grievance & Appeals Resolution Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).
Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).
Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).
Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).
Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-855-705-8823** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.
Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):
Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.
Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).
Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

PRI-041-322

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Policy #:	HH.3001Δ
Title:	**Member Access to Designated Record Set**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	~~05/01~~12/07/17
Last Revised Date:	~~05/01~~12/07/17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy defines the Designated Record Set (DRS) that contains Protected Health Information (PHI) for a Member, maintained by CalOptima and the conditions under which the Member may access, inspect, or obtain a copy of his or her PHI in the DRS.

II. POLICY

A. Members shall have the right to access, inspect, or obtain a copy of their PHI in the DRS for as long as CalOptima maintains the PHI record.

1. Records are retained in accordance with CalOptima Policy HH.2022Δ: Record Retention and Access.

B. CalOptima shall provide a Member with access to their PHI in the format requested by the Member, if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by CalOptima and the Member.

C. If the Member requests their PHI to be sent via mail, CalOptima may impose a reasonable, cost-based fee for postage.

~~B.~~D. CalOptima shall grant a Member's Authorized Representative access to a Member's PHI, in accordance with CalOptima Policies HH.3009Δ: Access by Member's Authorized Representative and HH.3015Δ: Authorization for Release of Protected Health Information.

~~C.~~E. Any person with knowledge of a violation, or potential violation, of this policy shall report such information to the Privacy Officer directly, or through the CalOptima Compliance and Ethics Hotline at 1-877-837-4417 or email: privacy@caloptima.org.

III. PROCEDURE

A. Requests for access to inspect or obtain a copy of DRS:

1. A Member shall submit a written request for access to inspect or ~~copy~~obtain a copy of his or her PHI in the DRS by submitting the Individual Request for Access to Protected Health

Information ~~Form,~~(PHI) Contained in the Designated Record Set Form to the Office of Compliance. A Member's Authorized Representative may request access to the Member's PHI in accordance with the requirements set forth in CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative.

2. The DRS does not include complete copies of records created and/or maintained by Providers or entities other than CalOptima. If a Member wants such records, they are advised to contact their doctor, ~~or clinic~~Health Network, or other health care provider.

3. CalOptima shall process a request to access, inspect or obtain copies of the DRS within thirty (30) calendar days after receipt of a complete written request.

~~3.~~4. If necessary, a thirty (30) calendar day extension may be used to retrieve ~~data located off-site~~information that is not readily available.

a. For extensions, CalOptima must provide the Member a written statement of the reasons for the delay and the date by which it may complete its action ~~(~~within the thirty (30) calendar day period~~) and it may only have one (1) extension~~.

b. CalOptima may only have one (1) such extension of time for action on a request for access to DRS.

~~4.~~5. The Office of Compliance shall notify the Member, in writing, of the determination on the request. The notice shall contain the information set forth in Section III.E. of this policy.

~~5.~~6. Verification of Member identification requesting access to inspect or copy the DRS:

a. If the Member makes such request in person to the Customer Service Department, Customer Service staff shall:

i. Request identification (e.g., Driver License or Member ID card ~~or a letter from CalOptima~~), or ask to verify the Member's date of birth or address based on FACETS™ data; and

ii. Provide the Member with a copy of the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set Form for the Member to complete.

b. If the Member request is received by mail or fax, the Office of Compliance staff shall ~~accept~~verify the ~~completed form as being from~~ identity of the ~~Member unless there is an error~~individual in ~~the information included on the request form that requires additional verification from the requestor.~~accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information.

~~6.~~7. The Office of Compliance shall accept the request from the Member as valid, provided all information on the request is complete and accurate. ~~-~~All requests shall include, as applicable:

a. An Authorization for ~~Use or Disclosure~~Release of Protected Health Information Form, as applicable, for Disclosure of a Member's PHI to a third party;

b. An Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set Form;

c. A written request that provides sufficient information, as necessary to identify the specific PHI sought;

d. Documentation that verifies the identity of the Member, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information.

~~7.~~8. The Office of Compliance shall review the request, determine if Member access is appropriate, and which parts of the DRS the Member cannot access.

~~8.~~9. The Office of Compliance shall deny Member access to the following:

a. Patient identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose;

~~a.~~b. Psychotherapy notes;

~~b.~~c. PHI compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action, or proceeding; or

~~c.~~d. PHI obtained from someone other than a Provider under a promise of confidentiality, and the access requested would be reasonably likely to reveal the source of the information.

~~d.~~e. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life, or physical safety, of the Member, or another person;

~~e~~f. The PHI makes reference to another person other than the Member, unless that person is a Provider, and a licensed health care professional has determined, in his or her professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

~~f~~g. The Authorized Representative requests for access, and a licensed health care professional has determined, in his or her professional judgment, that the provision of access to such Authorized Representative is reasonably likely to cause substantial harm to the individual, or another person.

~~9.~~10. If the denial is based on any of the reasons as stated in Section III.A.9~~.c~~ e~~.~~, - g, a Member can request to have the denial reviewed by another licensed health care professional by submitting a written request to the CalOptima Privacy Officer at 505 City Parkway West, Orange, CA 92868.

~~10.~~11. The Office of Compliance shall route the request to the department(s), or Business Associate responsible for creating, or maintaining, the requested record(s).

12. The responsible department, or Business Associate, shall send a copy of the requested PHI to the Office of Compliance within fourteen (14) calendar days of receiving the request.

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B. The following departments within CalOptima shall have responsibility for the DRS, as follows:

1. Customer Service ~~Department~~;

~~2. Finance Department;~~

~~3.~~2. Information Systems ~~(IS)~~;

~~4.~~3. Claims Administration;

4. Utilization Management;

5. Case Management;

~~a. Prior Authorization records only; or~~

~~b. Case, or Medical Management, records only.~~

6. Pharmacy;

~~a. Prior Authorization records only.~~

7. Grievance and Appeals Resolution Services;

8. Enrollment;

~~8.~~9. Multipurpose Senior Services Program (MSSP~~):~~); and

~~a. Prior Authorization records only.~~

~~9.~~10. Long Term Care (LTC~~):~~).

~~a. Case, or Medical Management, Records.~~

C. Department staff shall consult the Privacy Officer if there is any doubt about the appropriateness of ~~releasing the PHI to the Member~~Member access to inspect or copy PHI from the DRS.

D. If CalOptima does not maintain the PHI that is the subject of the Member's request for access, and CalOptima knows where the requested information is maintained, CalOptima shall inform the Member of the entity to whom the Member may direct such request.

E. Notification to Member:

1. The Office of Compliance shall notify the Member regarding the record request as follows:

a. Approved: If CalOptima approves the Member's request, CalOptima shall provide the Member with the records requested, in accordance with the format and method designated on the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set Form within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed.

b. Denied: If CalOptima denies the Member's request, CalOptima shall send a letter to the Member within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed, informing the Member of the decision, the reason for denial, and instructions on Member's appeal rights to have the materials reviewed, if applicable. The denial notice shall include a description of how a Member may complain to CalOptima, or the Office of Civil Rights (OCR), and contact information for how to file a complaint with CalOptima.

c. Approved or denied, in whole or in part: If CalOptima approves a portion of the Member's request and also denies portion of the request, CalOptima shall provide the Member with the records requested in accordance with Section III.E.1.a of this Policy. CalOptima shall also provide a letter informing the Member of the denial, in accordance with Section III.E.1.b of this policy.

F. Documentation

1. The Office of Compliance shall retain a record of the requests and related letters, including a copy of information released to the Member, for ten (10) years from the date of the release.

G. The following table summarizes the content of CalOptima's DRS:

DRS Content	Source	Media Type For Member
~~**Enrollment Records**~~ Enrollment Form from Member	Customer Service	Paper Form
Auto-Assignment and Health Network changes *(Not applicable to Medi-Cal members)*	~~IS~~Customer Service	Print out/report ~~-~~from FACETS™ Excluded: Customer Service Notes and Call Recordings

DRS Content	Source	Media Type For Member
~~**Payment Records**~~ (1) Eligibility Records	~~IS~~ Customer Service	Print out/report from FACETS™
(2) Claims Records	Claims	~~Paper copy from microfiche~~ Print out/report from FACETS™
(3) Prior, current and retrospective Authorization Records ~~(~~ARF/PA request and ~~attachments~~*~~,~~, notice of action (NOA) letters)	~~Care Coordination~~ Utilization Management	Print out/report from FACETS™, clinical systems. Paper copy from ARF/PA File~~, shared drive, or CD rom.~~,.
	Pharmacy	Paper copy Summary- Pharmacy Benefit Manager (PBM) data files
~~*Note: Excludes Medical Records created and maintained by Providers.~~(4) Prior, current and retrospective Authorization Records (Pharmacy) (5) Grievance and Appeals Resolution letters (Pharmacy) (6) Prior Authorization Records	MSSP LTC	Paper copy Print out/report from MSSP database Paper copy, Print out/report from LTC database
~~**Case or Medical Management Record**~~ Entries in Care Management Data Systems including contacts with Member or other coordination activities used in making decisions about the Member.	~~Care Coordination~~Case Management	Paper copy Summary reports from clinical systems and data base files. Excludes: Case or ~~Medical Management~~medical management notes created by Providers or Health Networks.
Excluded: Patient-identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.		Examples include protocols, practice guidelines, accreditation reports, best practice guidelines, public health records, statistical reports, MDS Report, patient identifiable data reviewed for quality assurance~~.~~, call recordings and internal department notes (e.g. Customer Service notes).

IV. ATTACHMENTS

A. Authorization for Release of Protected Health Information (PHI)
B. Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form
C. Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set
D. Letter: Denial of Access-Subject to review
E. Letter: Denial of Access-Not Subject to review

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Notice of Privacy Practices
F. CalOptima Policy HH.2022Δ: Record Retention and Access
~~F.~~G. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information
~~G.~~H. CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative
~~H.~~I. CalOptima Policy HH.3015Δ: Authorization for Release of Protected Health Information (PHI)
~~I.~~J. CalOptima Privacy Program
~~J.~~K. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~K.~~L. NCQA Standard MED5 Privacy and Confidentiality: Element A~~: Adopting Written Policies,~~:, Factor 2 – 2017
~~L.~~M. Title 45, Code of Federal Regulations (C.F.R.), §164.501
~~M.~~N. Title 45, Code of Federal Regulations (C.F.R.), §164.524
~~N.~~O. Title 45, Code of Federal Regulations (C.F.R.), §164.530(j)(2)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3001	Member Access to Designated Record Set	Medi-Cal
Effective	08/01/2005	MA.9203	Member Access to Designated Record Set	OneCare
Revised	04/01/2007	HH.3001	Member Access to Designated Record Set	Medi-Cal

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Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	07/01/2008	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2008	MA.9203	Member Access to Designated Record Set	OneCare
Revised	07/01/2011	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2011	MA.9203	Member Access to Designated Record Set	OneCare
Revised	01/01/2013	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	01/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	06/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	11/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	11/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	09/01/2015	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2015	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE
Revised	05/01/2017	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Term	Definition
Designated Record Set	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: 1. The medical records and billing records about individuals maintained by or for a covered health care provider; 2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI~~) ONLY~~)

HIPAA privacy regulations ~~require~~require you to complete ~~all~~ **ALL** ~~required~~ sections of this form to authorize CalOptima to release your protected health information (PHI) to another person or ~~entity~~agency. This form is **ONLY** for release of information. It will not give the authorized representative the ability to make health care changes on the member's behalf in any way.~~This form is intended **ONLY** for release of information.~~

SECTION A: Member Information~~Authorizing Release of PHI *REQUIRED*~~

Last~~Member's~~ Name: _____ ~~Member~~ First Name:~~CIN:~~ _____

CIN: _____ Date of Birth: _____
mm/dd/yyyy

Address: _____
Street/Unit Number *City* *ST* *Zip Code*

Best ~~Phone~~ phone ~~(Home):~~number to contact you at: ~~Member Date of Birt~~Phone ~~(Cellh):~~

SECTION B: Information that Can Be Released

I allow the following information to be released by CalOptima:

☐ Any and all information pertaining to my ~~protected health information~~PHI; OR
☐ Limit the use and disclosure of ~~information~~PHI to the following (Please specify):
_____

NOTE: The following types of information will not be released unless specifically authorized. I specifically authorize the release of the following health information (initials required if any of the following boxes are checked):

Mental health treatment information Initial: _____

Alcohol / drug treatment information Initial: _____

SECTION C: Purpose of this Authorization

~~This protected health information is being disclosed for the following purpose(s) (Please select one):~~Please describe the purpose or reason for sharing or using PHI.

☐ ~~At the request of the member~~Personal Use

☐ Insurance ☐~~-~~

~~Other (Please specify.):~~

☐ Legal

☐ Other (Please specify.):~~_____~~ _____

SECTION ~~D~~DB: Person(s) or ~~Entity~~Agency(ies) Authorized to Receive ~~this Information~~PHI ~~*REQUIRED*~~

~~Please enter the person(s) or organization who will receive member's PHI. This information may be disclosed to, and used by, the following person(s) or entity(entity (ies).~~ By filling out Section D, I am letting CalOptima use or share my PHI with the person or agency below. I know this authorization starts when I sign and return this form.

The representative receiving the information must be 18 years of age or older.

Representative/Agency's~~'s~~ Name(s): _____

Relationship to Member: _____ Phone: _____

~~SECTION C: Information that Can Be Released *REQUIRED*~~

~~**I allow the following information to be released by CalOptima:**~~

~~☐ Any and all information pertaining to my health information; OR~~

~~☐ Only the following records or types of health information (Please specify.):~~

_____

~~SECTION D: Purpose of this Authorization *REQUIRED*~~

~~This protected health information is being disclosed for the following purpose(s) (Please select one.):~~

~~☐ At the request of the member~~

~~☐ Other (Please specify.):~~ _____

SECTION E: My Rights

- ~~I understand that I have the right to withdraw this authorization, in writing, at any time by sending written notification to: CalOptima, Attn: Customer Service Department.~~
- You may stop this authorization, in writing, at any time by sending written notification to: CalOptima, Attn: Enrollment & Reconciliation Department.

SECTION E: My Rights Continued

- ~~I also understand that my revocation is not effective to the extent that the persons I have authorized to disclose my protected health information have acted in reliance upon this authorization prior to receipt of the revocation.~~Sending a letter to stop this authorization will not change how CalOptima used or shared my PHI before getting my letter.
- ~~I understand my authorization to release this information will not affect my eligibility or enrollment status, or any treatment or benefit payment decisions. I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy laws.~~The person or agency who gets my PHI from CalOptima may show it to others. In this case, your PHI may no longer be protected by HIPAA Privacy Rules.
- ~~I release CalOptima from any liability associated with releasing this information to the person/agency named above. I understand that I may have the right under federal or state law to inspect or copy the protected health information to be disclosed.~~You do not have to fill out or sign this form. Not filling out this form will not affect your ability to obtain benefits, receive payment of your claims or otherwise affect your eligibility with CalOptima in any way.
- ~~I understand I have the right to refuse to sign this authorization.~~
- You have the right to look at or get a copy of your PHI that is being used or shared by this authorization.

SECTION F: Expiration Date of Authorization

By filling out Section F, I am letting CalOptima know when my PHI can no longer be used or shared with others. **If a specific date is not provided, this authorization will expire one (1) year after the signature date:**

This authorization expires on: _____

mm/dd/yyyy

_____

~~SECTION F: Expiration Date of Authorization *REQUIRED*~~

This authorization will remain in effect until the date or event specified below becomes effective on signature date and will end on: . If no end date is indicated or event is specified, this authorization will automatically expire three (3) years from after the date of signature: signature date.

☐ This authorization expires on: _____ ; **OR**

mm/dd/yyyy

☐ Upon the following event (must relate to member or to the purpose of this authorization):

_____

SECTION G: Signature
REQUIRED

By signing below, I acknowledge understand that I have the right to get receiving a copy of this authorization. Please be advised that in order to process your request, a copy of a valid valid, government-issued photo identification (ID) with your signature must be included with your request form or your signature must be notarized. I have read this form and know what it means.

Signature**:** _____ Date: _____
(Member/Legal Representative) *mm/dd/yyyy*

If signed by a person other than the member, indicate relationship:
If signed by a person other than the member p Print
n Name: _____
(Legal Representative)
If signed by a person other than the member, description of representative's authority to act for the individual:

_____
Please provide a description of representative's authority to act for the individual:

_____

* CalOptima reserves the right to request legal documentation (e.g. birth certificate, court order, etc.) from the Legal Representative signing on behalf of a Member.

Please submit the completed form to:
CalOptima
505 City Parkway West
Orange, CA 92868
Fax: (714) 338-3104
STOP

Please return this form to the address or fax number listed at the bottom of this page.

For CalOptima Use Only:

~~Staff Name:~~

~~Date Verified:~~

Staff Name: _____ How was identity verified? ~~Date Verified:~~ In person/Phone

Signature: Date verified:

Instruction Sheet for CalOptima
Health Insurance Portability and Accountability Act (HIPAA) Authorization
for Release of Protected Health Information (PHI)

SECTION A: MEMBER AUTHORIZING RELEASE

This section applies to the member who is asking for the release of his or her information to another person or organization. Please complete all items of information in this section.

SECTION B: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the name(s) of the person(s) or organization(s) that you are authorizing to access your PHI. For example, if you are authorizing your spouse, adult child, or any other individual to obtain your PHI, enter his/her name in these spaces. If you are authorizing an organization (such as a broker, law firm, insurance agency, etc.) to obtain your PHI, enter the specific name of the organization in these spaces. **Examples include:** ***"Dr. John Smith" or "Mary Doe (spouse)."*** Indicate how the person(s) or organization(s) is related to you (for example, spouse, adult child, etc.) and provide their phone number.

SECTION C: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release. Be specific regarding the types of documents you are authorizing for release. For example, if you are authorizing an individual to obtain PHI related to a recent medical event, specify the date of the medical event, the types of documents you are requesting (e.g. billing records, pre-authorization records, or pharmacy records) and state any types of records you would like to exclude.

SECTION D: PURPOSE OF THIS AUTHORIZATION

Select the reason(s) you've asked for the release of your information. If you have a specific reason, please fill in under "**Other**" and indicate the reason. For example, if you only want the person(s) or organization(s) you are authorizing to receive your protected health information for a pending claims appeal, you would enter ***"To appeal a claim determination"*** or something similar in that block.

SECTION E: EXPIRATION DATE OF AUTHORIZATION

Check the first box if you want the authorization to end on a certain date. Enter in the date of expiration. Check the second box if you wish for the authorization to expire on a certain event, for example, "***one year from my signature date***."

SECTION F: REVIEW AND APPROVAL

If you are the member, sign your name and enter the date you signed the form. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.**

If you are the member's personal representative, sign your name, enter the date you signed the form and indicate your representative relationship. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.** You **must** also provide us with a copy of the legal documentation indicating you are the authorized personal representative of the member.

- Examples of legal documents:
  - **Power of Attorney for Health Care~~, General or Durable Power of Attorney~~** — this document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
  - **Legal Guardianship** — this is when the court appoints someone to care for another person.
  - **Conservatorship of the Person** — this happens when the court appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
  - **Executor of Estate** — this type of document would be used when the person who is being represented has died.

Please keep a copy of the form for your records.

Individual Request for Access to ~~Personal~~ Protected Health Information (PHI) Contained in the Designated Record Set (DRS)

CalOptima members~~,~~, past and current, can request copies of their individual Protected Health Information (PHI). As required by the ~~California Welfare and Institutions C~~code ~~and the Federal~~ Health Insurance Portability and Accountability Act (HIPAA)~~, ,~~ m~~m~~embers have the right of access to inspect and obtain a copy of their ~~health information~~PHI ~~contained~~contained in a **d~~D~~esignated r~~R~~ecord s~~S~~et ~~-~~ (DRS)**. ~~CalOptima members, past and current, can request copies of their individual Protected Health Information (PHI).~~
This right does not apply to information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action hearing. Additional records may be excluded as well, including, but not limited to, customer service notes, records related to health care operations, etc.

CalOptima will act upon this request within 30 calendar days from the date CalOptima receive a complete~~s thi~~s request. However, i~~I~~f the information is not readily available ~~on site~~, CalOptima may have ~~then it can take~~ up to 60 calendar days from the date CalOptima receives it to act upon this request. ~~or within 60 calendar days from the date CalOptima receives the request if the requested information that is produced by CalOptima is not maintained or accessible to CalOptima on site.~~ CalOptima will either inform you of the acceptance of the request and provide you with the requested information, in whole or in part, ~~access~~ or provide a written denial explaining the reasons for the denial, in whole or in part, and whether you are entitled to have the denial reviewed. CalOptima may charge a fee of $0.10 per page and any postage fees if you ask for the records to be mailed to you.

To Request a Copy of Your PHI in a ~~Medical Records~~DRS:

~~1.~~ Please complete the entire form including your full legal name, your 8-digit ~~CalOptima~~ CalOptima-~~i~~issued CIN number, your date of birth ~~(DOB)~~ and the best ~~tele~~phone number ~~we~~ to~~can~~ reach you ~~at~~. ~~Please print legibly.~~

1. **Please be advised that in order to process your request, a valid photo ~~ID~~ identification (ID) with signature must be included with your request form**. Please print legibly.

~~2.~~ If ~~the form is signed by a member's~~you would like to designate ~~authorized~~ a personal representative to have access to your PHI, then ~~the authorized representative must provide legal documentation that he/she is authorized to act on the member's~~~~your behalf~~you must also complete the CalOptima Authorization for Release of Protected Health Information form. Requests submitted by your personal representative are subject to adequate identification/verification.

2.

3. Please select ~~only~~ the categories of records ~~necessary to fulfill your need~~you are requesting from the list provided or specify under "Other" the types of records you would like. If you are unsure of what you need, please contact CalOptima Customer Service at **1-~~(~~888~~)~~ -587-8088** for assistance.

4. Please note that ~~CalOptima members who~~ if you were assigned to a health network (e.g. Monarch, AltaMed, etc.) during any portion of the date range requested, you should also ~~consult~~ contact ~~their~~ that

health network. **CalOptima does not maintain or have access to medical records compiled by hHealth nNetworks, hHospitals or pPhysicians' oOffices (e.g. immunization records, x-ray films, lab results, etc.).**

5. If you have any questions or concerns regarding your request for access to your personal health informationDRS, please contact CalOptima Customer Service toll--free at (1-888) -587-8088, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD/TTY line at **1-714-246-8523** or toll-free at **1-800-735-2929**. We have staff who can speak your language.-

6. Your Medical recordDRSs may be picked up on site at the CalOptima's oOffice or sent via electronic mail or certified postal mail. CalOptima will provide your Personal Health Information (PHI) by pick up, mail or email. PHI Requests for records to be faxed are subject to approval by CalOptima. may also be faxed upon approval. Records sent via e-mail emails containing PHI are will be sent secure (encrypted) to the e-mail address provided to CalOptima; with encryption; however, CalOptima shall not be held responsible for loss of PHI on personal email accounts.

Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS)

~~Individual Request for Access to Personal Protected Health Information (PHI)~~

Member Name: _____ Date of Birth:CalOptima CIN#: _____

Please Print (Last, First, MI) *(mm/dd/yyyy)*

TelepPhone: (_ _ _ _ _ _) DOBDate of BirthCalOptima CIN: _____

Please indicate specifically the information to which you are requesting access:The types of records listed below are generally part of the DRS maintained by CalOptima. Please select the category(ies) of records you wish to inspect/copy:

☐ Medical Claims Record(s)
☐ Medical Authorization Request(s)
☐ Care Management Record(s)

☐ Pharmacy Claims Record(s)
☐ Pharmacy Prior Authorization(s) (PA)
☐ Notice(s) of Action
☐ State Hearing Statement(s)
☐ Eligibility Record(s)☐ Enrollment Form
☐ Enrollment Form(s) (*Does not apply to Medi-Cal Members*)

Please specify date range neededI am requesting copies of records for the following dates of service:

__/__/____ to __/__/____
(mm/dd/yyyy) *(mm/dd/yyyy)*

Please note, requests submitted without a date range will be considered incomplete.

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☐ Other, please explain:

☐ Other, please explain:	

Please indicate the reason for this request:

Delivery Method method Requested requested (select one):

☐ ✂Personal" On sitePpick--up at Cal Optima at CalOptima Customer Service*(subject to adequate identification/verification at the time of pick-up)*

☐ Email:

☐

Mail: _____

Street/Unit *City* *State* *ZipIPip*

☐ Fax *(Upon approval)*: ( )☐ Fax *(Upon approval):* _____ ☐ Email: _____

Identifying information is required (select one):

☐ Address verification attached (e.g. utility bill, phone bill, etc.)

☐ Copy of identification attached (e.g. valid driver's license, birth certificate, benefits ID card, etc.)

☐ (*If no identification is attached, your signature must be notarized.*)

Notarized By: _____

Notary Public Number: _____

Date: _____

Unofficial Unless Stamped by Notary Public

I declare under penalty of perjury that the information on this form is true to the best of my knowledge.

CalOptima may charge a fee of $0.10 per page, and any postage fees if you ask for the records to be mailed to you. I hereby authorize CalOptima to release the requested medical recordDRSs to myselfe.

Member

Signature: _____ Date: _____

(Member/Personal Representative) *(mm/dd/yyyy)*

For Authorized Representative or Legal Guardian Use Only

If signed by a person other than the member, indicate relationship:Name:

Relationship to Member:

Signature:Print Name: _____ *(subject to adequate identification/verification)* Date:

Please submit the completed, and signed request form to CalOptima either in person or , by mail, or by fax. or email.

CalOptima

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Attn: Office of Compliance (Privacy)
505 City Parkway West
Orange, CA 92868

Fax: **1-714-481-6457**~~Email: privacy@caloptima.org~~
~~• Fax: 1 (714) 481 6457~~

[DATE]

[NAME]
[ADDRESS]
[CITY], [STATE] [ZIP]

Member Name:
Member CIN:

Re: Response to Request for Access to Protected Health Information (PHI)

Dear [NAME]:

CalOptima has received your request for access to Protected Health Information (PHI) dated [DATE], regarding the above named member. A licensed healthcare professional has reviewed this request, and has denied access to the information. Under federal law, we are not required to provide the information because [REASON].

If you wish to have the denial reviewed by another licensed health care professional, you may submit a written request for review. This request should be submitted to:

CalOptima Privacy Officer
505 City Parkway West
Orange, CA, 92868

Should you have any questions regarding this denial, you may contact the Office of Compliance at CalOptima by calling [Number].

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also available on our website at www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima's Customer Service Department at 1-714-246-8500.

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of your privacy rights.

Sincerely,

Privacy Officer
CalOptima

[DATE]

[NAME]
[ADDRESS]
[CITY], [STATE] [ZIP]

Member Name:
Member CIN:

Re: Response to Request for Access to Protected Health Information (PHI)

Dear [NAME]:

CalOptima has received your request for access to Protected Health Information (PHI) dated [DATE] regarding the above named member. A licensed healthcare professional has reviewed this request and denied access to the information. Under federal law, we are not required to provide the information because [REASON].

This denial is final and is not subject to review according to federal law.

Should you have any questions regarding this denial, you may contact the Office of Compliance at CalOptima by calling [Number].

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also available on our website at www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima's Customer Service Department at 1-714-246-8500.

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of your privacy rights.

Sincerely,

Privacy Officer
CalOptima

Policy #:	HH.3001Δ
Title:	**Member Access to Designated Record Set**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/07/17
Last Revised Date:	12/07/17

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

I. PURPOSE

This policy defines the Designated Record Set (DRS) that contains Protected Health Information (PHI) for a Member, maintained by CalOptima and the conditions under which the Member may access, inspect, or obtain a copy of his or her PHI in the DRS.

II. POLICY

A. Members shall have the right to access, inspect, or obtain a copy of their PHI in the DRS for as long as CalOptima maintains the PHI record.

1. Records are retained in accordance with CalOptima Policy HH.2022Δ: Record Retention and Access.

B. CalOptima shall provide a Member with access to their PHI in the format requested by the Member, if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by CalOptima and the Member.

C. If the Member requests their PHI to be sent via mail, CalOptima may impose a reasonable, cost-based fee for postage.

D. CalOptima shall grant a Member's Authorized Representative access to a Member's PHI, in accordance with CalOptima Policies HH.3009Δ: Access by Member's Authorized Representative and HH.3015Δ: Authorization for Release of Protected Health Information.

E. Any person with knowledge of a violation, or potential violation, of this policy shall report such information to the Privacy Officer directly, or through the CalOptima Compliance and Ethics Hotline at 1-877-837-4417 or email: privacy@caloptima.org.

III. PROCEDURE

A. Requests for access to inspect or obtain a copy of DRS:

1. A Member shall submit a written request for access to inspect or obtain a copy of his or her PHI in the DRS by submitting the Individual Request for Access to Protected Health

Information (PHI) Contained in the Designated Record Set Form to the Office of Compliance. A Member's Authorized Representative may request access to the Member's PHI in accordance with the requirements set forth in CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative.

2. The DRS does not include complete copies of records created and/or maintained by Providers or entities other than CalOptima. If a Member wants such records, they are advised to contact their doctor, Health Network, or other health care provider.

3. CalOptima shall process a request to access, inspect or obtain copies of the DRS within thirty (30) calendar days after receipt of a complete written request.

4. If necessary, a thirty (30) calendar day extension may be used to retrieve information that is not readily available.

   a. For extensions, CalOptima must provide the Member a written statement of the reasons for the delay and the date by which it may complete its action within the thirty (30) calendar day period.

   b. CalOptima may only have one (1) such extension of time for action on a request for access to DRS.

5. The Office of Compliance shall notify the Member, in writing, of the determination on the request. The notice shall contain the information set forth in Section III.E. of this policy.

6. Verification of Member identification requesting access to inspect or copy the DRS:

   a. If the Member makes such request in person to the Customer Service Department, Customer Service staff shall:

      i. Request identification (e.g., Driver License or Member ID card), or ask to verify the Member's date of birth or address based on FACETS™ data; and

      ii. Provide the Member with a copy of the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set Form for the Member to complete.

   b. If the Member request is received by mail or fax, the Office of Compliance staff shall verify the identity of the individual in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information.

7. The Office of Compliance shall accept the request from the Member as valid, provided all information on the request is complete and accurate. All requests shall include, as applicable:

   a. An Authorization for Release of Protected Health Information Form, as applicable, for Disclosure of a Member's PHI to a third party;

   b. An Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set Form;

c. A written request that provides sufficient information, as necessary to identify the specific PHI sought;

d. Documentation that verifies the identity of the Member, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information.

8. The Office of Compliance shall review the request, determine if Member access is appropriate, and which parts of the DRS the Member cannot access.

9. The Office of Compliance shall deny Member access to the following:

a. Patient identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose;

b. Psychotherapy notes;

c. PHI compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action, or proceeding; or

d. PHI obtained from someone other than a Provider under a promise of confidentiality, and the access requested would be reasonably likely to reveal the source of the information.

e. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life, or physical safety, of the Member, or another person;

f. The PHI makes reference to another person other than the Member, unless that person is a Provider, and a licensed health care professional has determined, in his or her professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

g. The Authorized Representative requests for access, and a licensed health care professional has determined, in his or her professional judgment, that the provision of access to such Authorized Representative is reasonably likely to cause substantial harm to the individual, or another person.

10. If the denial is based on any of the reasons as stated in Section III.A.9 e - g, a Member can request to have the denial reviewed by another licensed health care professional by submitting a written request to the CalOptima Privacy Officer at 505 City Parkway West, Orange, CA 92868.

11. The Office of Compliance shall route the request to the department(s), or Business Associate responsible for creating, or maintaining, the requested record(s).

12. The responsible department, or Business Associate, shall send a copy of the requested PHI to the Office of Compliance within fourteen (14) calendar days of receiving the request.

B. The following departments within CalOptima shall have responsibility for the DRS, as follows:

1. Customer Service;
2. Information Systems;
3. Claims Administration;
4. Utilization Management;
5. Case Management;
6. Pharmacy;
7. Grievance and Appeals Resolution Services;
8. Enrollment;
9. Multipurpose Senior Services Program (MSSP); and
10. Long Term Care (LTC).

C. Department staff shall consult the Privacy Officer if there is any doubt about the appropriateness of Member access to inspect or copy PHI from the DRS.

D. If CalOptima does not maintain the PHI that is the subject of the Member's request for access, and CalOptima knows where the requested information is maintained, CalOptima shall inform the Member of the entity to whom the Member may direct such request.

E. Notification to Member:

1. The Office of Compliance shall notify the Member regarding the record request as follows:

a. Approved: If CalOptima approves the Member's request, CalOptima shall provide the Member with the records requested, in accordance with the format and method designated on the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set Form within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed.

b. Denied: If CalOptima denies the Member's request, CalOptima shall send a letter to the Member within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed, informing the Member of the decision, the reason for denial, and instructions on Member's appeal rights to have the materials reviewed, if applicable. The denial notice shall include a description of how a Member may complain to CalOptima, or the Office of Civil Rights (OCR), and contact information for how to file a complaint with CalOptima.

c. Approved or denied, in whole or in part: If CalOptima approves a portion of the Member's request and also denies portion of the request, CalOptima shall provide the Member with the records requested in accordance with Section III.E.1.a of this Policy. CalOptima shall

also provide a letter informing the Member of the denial, in accordance with Section III.E.1.b of this policy.

F. Documentation

1. The Office of Compliance shall retain a record of the requests and related letters, including a copy of information released to the Member, for ten (10) years from the date of the release.

G. The following table summarizes the content of CalOptima's DRS:

DRS Content	**Source**	**Media Type For Member**
Enrollment Form from Member	Customer Service	Paper Form
Auto-Assignment and Health Network changes *(Not applicable to Medi-Cal members)*	Customer Service	Print out/report from FACETS™ Excluded: Customer Service Notes and Call Recordings
(1) Eligibility Records	Customer Service	Print out/report from FACETS™
(2) Claims Records	Claims	Print out/report from FACETS™
(3) Prior, current and retrospective Authorization Records (ARF/PA request and attachments, notice of action (NOA) letters)	Utilization Management	Print out/report from FACETS™, clinical systems. Paper copy from ARF/PA File
(4) Prior, current and retrospective Authorization Records (Pharmacy)	Pharmacy	Paper copy Summary- Pharmacy Benefit Manager (PBM) data files
(5) Grievance and Appeals Resolution letters (Pharmacy)		
(6) Prior Authorization Records	MSSP	Paper copy Print out/report from MSSP database
	LTC	Paper copy, Print out/report from LTC database
Entries in Care Management Data Systems including contacts with Member or other coordination activities used in making decisions about the Member.	Case Management	Paper copy Summary reports from clinical systems and data base files. Excludes: Case or medical management notes created by Providers or Health Networks.

DRS Content	Source	Media Type For Member
Excluded: Patient-identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.		Examples include protocols, practice guidelines, accreditation reports, best practice guidelines, public health records, statistical reports, MDS Report, patient identifiable data reviewed for quality assurance, call recordings and internal department notes (e.g. Customer Service notes).

IV. ATTACHMENTS

A. Authorization for Release of Protected Health Information (PHI)
B. Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form
C. Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set
D. Letter: Denial of Access-Subject to review
E. Letter: Denial of Access-Not Subject to review

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Notice of Privacy Practices
F. CalOptima Policy HH.2022Δ: Record Retention and Access
G. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information
H. CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative
I. CalOptima Policy HH.3015Δ: Authorization for Release of Protected Health Information (PHI)
J. CalOptima Privacy Program
K. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
L. NCQA Standard MED5 Privacy and Confidentiality: Element A: Factor 2 – 2017
M. Title 45, Code of Federal Regulations (C.F.R.), §164.501
N. Title 45, Code of Federal Regulations (C.F.R.), §164.524
O. Title 45, Code of Federal Regulations (C.F.R.), §164.530(j)(2)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
B. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3001	Member Access to Designated Record Set	Medi-Cal
Effective	08/01/2005	MA.9203	Member Access to Designated Record Set	OneCare
Revised	04/01/2007	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2008	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2008	MA.9203	Member Access to Designated Record Set	OneCare
Revised	07/01/2011	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2011	MA.9203	Member Access to Designated Record Set	OneCare
Revised	01/01/2013	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	01/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	06/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	11/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	11/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	09/01/2015	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2015	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE
Revised	05/01/2017	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Term	Definition
Designated Record Set	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: 1. The medical records and billing records about individuals maintained by or for a covered health care provider; 2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

HIPAA privacy regulations require you to complete **ALL** sections of this form to authorize CalOptima to release your protected health information (PHI) to another person or agency. This form is **ONLY** for release of information. It will not give the authorized representative the ability to make health care changes on the member's behalf in any way.

SECTION A: Member Information

Last Name: _____ First Name: _____

CIN: _____ Date of Birth: _____
mm/dd/yyyy

Address: _____
Street/Unit Number *City* *ST* *Zip Code*

Best phone number to contact you at: _____

SECTION B: Information that Can Be Released

I allow the following information to be released by CalOptima:

☐ Any and all information pertaining to my PHI; OR

☐ Limit the use and disclosure of PHI to the following (Please specify):

NOTE: The following types of information will not be released unless specifically authorized. I specifically authorize the release of the following health information (initials required if any of the following boxes are checked):

Mental health treatment information Initial:_____

Alcohol / drug treatment information Initial:_____

SECTION C: Purpose of this Authorization

Please describe the purpose or reason for sharing or using PHI.

☐ Personal Use ☐ Legal

☐ Insurance ☐ Other (Please specify.):_____

SECTION D: Person(s) or Agency(ies) Authorized to Receive PHI

By filling out Section D, I am letting CalOptima use or share my PHI with the person or agency below. I know this authorization starts when I sign and return this form. The representative receiving the information must be 18 years of age or older.

Representative/Agency's Name(s): _____

Relationship to Member: _____ Phone: _____

SECTION E: My Rights

- You may stop this authorization, in writing, at any time by sending written notification to: CalOptima, Attn: Enrollment & Reconciliation Department.

SECTION E: My Rights Continued

- Sending a letter to stop this authorization will not change how CalOptima used or shared my PHI before getting my letter.
- The person or agency who gets my PHI from CalOptima may show it to others. In this case, your PHI may no longer be protected by HIPAA Privacy Rules.
- You do not have to fill out or sign this form. Not filling out this form will not affect your ability to obtain benefits, receive payment of your claims or otherwise affect your eligibility with CalOptima in any way.
- You have the right to look at or get a copy of your PHI that is being used or shared by this authorization.

SECTION F: Expiration Date of Authorization

By filling out Section F, I am letting CalOptima know when my PHI can no longer be used or shared with others. **If a specific date is not provided, this authorization will expire one (1) year after the signature date:**

This authorization expires on: _____
mm/dd/yyyy

SECTION G: Signature

By signing below, I understand that I have the right to get a copy of this authorization. Please be advised that in order to process your request, a copy of valid, government-issued identification (ID) must be included with your request form or your signature must be notarized. I have read this form and know what it means.

Signature**:** _____ Date: _____
(Member/Legal Representative) *mm/dd/yyyy*

If signed by a person other than the member print name: _____
(Legal Representative)

Please provide a description of representative's authority to act for the individual:

* CalOptima reserves the right to request legal documentation (e.g. birth certificate, court order, etc.) from the Legal Representative signing on behalf of a Member.

STOP

Please return this form to the address or fax number listed at the bottom of this page.

For CalOptima Use Only:

Staff Name: _____ How was identity verified? In person/Phone

Signature: Date verified:

Instruction Sheet for CalOptima
Health Insurance Portability and Accountability Act (HIPAA) Authorization
for Release of Protected Health Information (PHI)

SECTION A: MEMBER AUTHORIZING RELEASE

This section applies to the member who is asking for the release of his or her information to another person or organization. Please complete all items of information in this section.

SECTION B: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the name(s) of the person(s) or organization(s) that you are authorizing to access your PHI. For example, if you are authorizing your spouse, adult child, or any other individual to obtain your PHI, enter his/her name in these spaces. If you are authorizing an organization (such as a broker, law firm, insurance agency, etc.) to obtain your PHI, enter the specific name of the organization in these spaces. **Examples include:** ***"Dr. John Smith" or "Mary Doe (spouse)."*** Indicate how the person(s) or organization(s) is related to you (for example, spouse, adult child, etc.) and provide their phone number.

SECTION C: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release. Be specific regarding the types of documents you are authorizing for release. For example, if you are authorizing an individual to obtain PHI related to a recent medical event, specify the date of the medical event, the types of documents you are requesting (e.g. billing records, pre-authorization records, or pharmacy records) and state any types of records you would like to exclude.

SECTION D: PURPOSE OF THIS AUTHORIZATION

Select the reason(s) you've asked for the release of your information. If you have a specific reason, please fill in under "**Other**" and indicate the reason. For example, if you only want the person(s) or organization(s) you are authorizing to receive your protected health information for a pending claims appeal, you would enter ***"To appeal a claim determination"*** or something similar in that block.

SECTION E: EXPIRATION DATE OF AUTHORIZATION

Check the first box if you want the authorization to end on a certain date. Enter in the date of expiration. Check the second box if you wish for the authorization to expire on a certain event, for example, "***one year from my signature date***."

SECTION F: REVIEW AND APPROVAL

If you are the member, sign your name and enter the date you signed the form. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.**

If you are the member's personal representative, sign your name, enter the date you signed the form and indicate your representative relationship. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.** You **must** also provide us with a copy of the legal documentation indicating you are the authorized personal representative of the member.

- Examples of legal documents:
    - **Power of Attorney for Health Care**— this document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
    - **Legal Guardianship** — this is when the court appoints someone to care for another person.
    - **Conservatorship of the Person** — this happens when the court appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
    - **Executor of Estate** — this type of document would be used when the person who is being represented has died.

Please keep a copy of the form for your records.

Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS)

CalOptima members, past and current, can request copies of their individual Protected Health Information (PHI). As required by the Health Insurance Portability and Accountability Act (HIPAA), members have the right of access to inspect and obtain a copy of their PHI contained in a **designated record set (DRS)**. This right does not apply to information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action hearing. Additional records may be excluded as well, including, but not limited to, customer service notes, records related to health care operations, etc.

CalOptima will act upon this request within 30 calendar days from the date CalOptima receive a completes request. However, if the information is not readily available, CalOptima may have up to 60 calendar days from the date CalOptima receives it to act upon this request. CalOptima will either inform you of the acceptance of the request and provide you with the requested information, in whole or in part, or provide a written denial explaining the reasons for the denial, in whole or in part, and whether you are entitled to have the denial reviewed. CalOptima may charge a fee of $0.10 per page and any postage fees if you ask for the records to be mailed to you.

To Request a Copy of Your PHI in a DRS:

1. Please complete the entire form including your full legal name, your 8-digit CalOptima-issued CIN number, your date of birth and the best phone number to reach you. **Please be advised that in order to process your request, a valid photo identification (ID) with signature must be included with your request form**. Please print legibly.

2. If you would like to designate a personal representative to have access to your PHI, then you must also complete the CalOptima Authorization for Release of Protected Health Information form. Requests submitted by your personal representative are subject to adequate identification/verification.

3. Please select the categories of records you are requesting from the list provided or specify under "Other" the types of records you would like. If you are unsure of what you need, please contact CalOptima Customer Service at **1-888-587-8088** for assistance.

4. Please note that if you were assigned to a health network (e.g. Monarch, AltaMed, etc.) during any portion of the date range requested, you should also contact that health network. **CalOptima does not maintain or have access to medical records compiled by health networks, hospitals or physicians' offices (e.g. immunization records, x-ray films, lab results, etc.).**

5. If you have any questions or concerns regarding your request for access to your DRS, please contact CalOptima Customer Service toll-free at **1-888-587-8088,** Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD/TTY line at **1-714-246-8523** or toll-free at **1-800-735-2929**. We have staff who can speak your language.

6. Your DRS may be picked up at CalOptima's office or sent via electronic mail or certified postal mail. Requests for records to be faxed are subject to approval by CalOptima. Records sent via email will be sent secure (encrypted) to the email address provided to CalOptima; however, CalOptima shall not be held responsible for loss of PHI on personal email accounts.

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Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS)

Member Name: _____ Date of Birth: _____
Please Print (Last, First, MI) *(mm/dd/yyyy)*

Phone: ( ) _____ CalOptima CIN: _____

The types of records listed below are generally part of the DRS maintained by CalOptima. Please select the category(ies) of records you wish to inspect/copy:

☐ Medical Claims Record(s)
☐ Medical Authorization Request(s)
☐ Care Management Record(s)
☐ Pharmacy Claims Record(s)
☐ Pharmacy Prior Authorization(s) (PA)
☐ Notice(s) of Action
☐ State Hearing Statement(s)
☐ Eligibility Record(s)
☐ Enrollment Form(s) (*Does not apply to Medi-Cal Members*)
☐ Other, please explain: _____

I am requesting copies of records for the following dates of service:
_____ to _____
(mm/dd/yyyy) *(mm/dd/yyyy)*

Please note, requests submitted without a date range will be considered incomplete.

Delivery method requested (select one):

☐Personal" pick-up at Cal Optima (*subject to adequate identification/verification at the time of pick-up)*

☐Mail: _____
Street/Unit *City* *State* *Zip*

☐ Fax *(Upon approval)*: ( ) _____ ☐Email: _____

Identifying information is required (select one):

☐ Copy of identification attached (e.g. valid driver's license, birth certificate, benefits ID card, etc.)

☐ *If no identification is attached, your signature must be notarized.*

Notarized By: _____

Notary Public Number: _____

Date: _____

Unofficial Unless Stamped by Notary Public

I declare under penalty of perjury that the information on this form is true to the best of my knowledge.

Signature: _____ Date: _____
(Member/Personal Representative) *(mm/dd/yyyy)*

If signed by a person other than the member, indicate relationship: _____

Print Name: _____ *(subject to adequate identification/verification)*

Please submit the completed and signed request form to CalOptima either in person, by mail or by fax.

CalOptima Attn: Office of Compliance (Privacy)
505 City Parkway West
Orange, CA 92868
Fax: **1-714-481-6457**

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[DATE]

[NAME]
[ADDRESS]
[CITY], [STATE] [ZIP]

Member Name:
Member CIN:

Re: Response to Request for Access to Protected Health Information (PHI)

Dear [NAME]:

CalOptima has received your request for access to Protected Health Information (PHI) dated [DATE], regarding the above named member. A licensed healthcare professional has reviewed this request, and has denied access to the information. Under federal law, we are not required to provide the information because [REASON].

If you wish to have the denial reviewed by another licensed health care professional, you may submit a written request for review. This request should be submitted to:

CalOptima Privacy Officer
505 City Parkway West
Orange, CA, 92868

Should you have any questions regarding this denial, you may contact the Office of Compliance at CalOptima by calling [Number].

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also available on our website at www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima's Customer Service Department at 1-714-246-8500.

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of your privacy rights.

Sincerely,

Privacy Officer
CalOptima

[DATE]

[NAME]
[ADDRESS]
[CITY], [STATE] [ZIP]

Member Name:
Member CIN:

Re: Response to Request for Access to Protected Health Information (PHI)

Dear [NAME]:

CalOptima has received your request for access to Protected Health Information (PHI) dated [DATE] regarding the above named member. A licensed healthcare professional has reviewed this request and denied access to the information. Under federal law, we are not required to provide the information because [REASON].

This denial is final and is not subject to review according to federal law.

Should you have any questions regarding this denial, you may contact the Office of Compliance at CalOptima by calling [Number].

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also available on our website at www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima's Customer Service Department at 1-714-246-8500.

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of your privacy rights.

Sincerely,

Privacy Officer
CalOptima

Policy #:	HH.3005Δ
Title:	**Member Request for Accounting of Disclosures**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/~~01/16~~07/17
Last Revised Date:	12/01/~~16~~17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy defines the scope of a Member's right to request an accounting of Disclosures made by CalOptima of the Member's Protected Health Information (PHI) created, or maintained, in a Designated Record Set (DRS) by CalOptima~~,~~ or its Business Associates.

II. POLICY

A. Upon a Member's request, CalOptima shall provide an accounting of PHI Disclosures released for a time period not to exceed six (6) years ~~and not prior to April 14, 2003~~.

1. Disclosures ~~Excepted~~excluded from ~~Accounting~~accounting include Disclosures:

a. ~~Used to provide Member care~~To carry out Treatment, Payment ~~for services, or~~ and Health Care Operations~~, including but not limited to, Disclosures to Providers, clearinghouses, and Business Associates~~;

~~b. Provided to the Member;~~

b. ~~Provided to~~To individuals of PHI about them;

c. Incident to a Use or Disclosure otherwise permitted or required;

d. Pursuant to an authorization;

e. For the facility's directory or to persons involved in the individual's care or other notification purposes as provided in 45 CFR §164.510;

~~c.~~f. For national security~~,~~ or intelligence purposes;

~~d.~~g. ~~Provided to~~To correctional ~~facilities,~~institutions or law enforcement officials;

~~e. Made pursuant to a Member's Authorization to Disclose;~~

~~f.~~h. ~~Part~~As part of a ~~Limited Data Set~~limited data set; or

~~g. Incidental to another permissible Use, or Disclosure.~~
i. That occurred prior to the compliance date for CalOptima.

B. The Office of Compliance shall track all other Disclosures of PHI not mentioned in Section II.A., in accordance with CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information.

C. Disclosure of PHI is not limited to hard-copy information and may include any information Disclosed by other means, such as verbally, electronic data release, or by facsimile.

D. CalOptima shall temporarily suspend a Member's right to receive an accounting of Disclosures ~~to~~pursuant to a request from a health oversight agency, or law enforcement official if:

1. CalOptima receives a written statement from such agency or official that an accounting to the Member would be reasonably likely to impede the agency's activities, and specifying the time for which such a suspension is required; or

2. A health oversight agency, or law enforcement official, provides a verbal statement to CalOptima, in which case CalOptima shall:

a. Document the statement, including the identity of the agency, or official, making the statement;

b. Temporarily suspend the Member's right to an accounting of Disclosures subject to the statement; and

c. Limit the temporary suspension to no longer than thirty (30) calendar days from the date of the oral statement, unless CalOptima receives a written request for suspension.

III. PROCEDURE

A. A Member may request an accounting of Disclosures of his or her PHI that CalOptima released, in the six (6) years prior to the date of the request (or lesser time, if requested), by submitting a Request for an Accounting of Disclosures Form to the Customer Service Department.

B. The Customer Service Department shall:

1. Provide the Member with a Request for an Accounting of Disclosures Form by U.S. mail, or in person~~,~~ at the CalOptima office; and

2. Assist the Member in completing the form, if necessary.

C. CalOptima's Customer Service Department shall forward all requests to the Privacy Officer, or Designee, who shall process the request.

D. CalOptima shall review a Member's request for an accounting of Disclosure from Members enrolled in a Health Network in coordination with the Health Network, or other Business Associate, as appropriate.

E. A written account of the Disclosures shall include:

1. Disclosures of PHI that occurred during the six (6) years, or shorter time period as designated on the Member's request, prior to the date of the request for an accounting~~;~~ specifying:

a. The date of the Disclosure;

b. The name of the entity, or person, who received the PHI, and if known, the address of such entity or person;

c. A brief description of the PHI Disclosed; and

d. A brief statement of the purpose of the Disclosure that reasonably informs the individual of the basis for the Disclosure, or in lieu of such statement, a copy of a written request for a Disclosure.

~~F.~~ F. If multiple requests were made by the same individual or entity, CalOptima shall provide the information required by Section III.E. for the first Disclosure and the frequency, periodicity, or number of Disclosures made during the accounting period requested by the Member and the date of the last such Disclosure during the accounting period requested by the Member. ~~If multiple requests were made by the same individual, or entity, the list will include the frequency, periodicity, number of times the information was released and the date of the last release during the period requested by the Member.~~

G. The Office of Compliance shall act on the Member's request, and:

1. Provide the Member with the PHI accounting within sixty (60) calendar days after the date of request; or

2. If the PHI accounting will not be prepared within the sixty (60) calendar days, communicate to the Member:

a. The reasons why the PHI accounting will not be prepared within sixty (60) calendar days;

b. The date in which the PHI accounting will be prepared; and

c. Complete the request within an additional thirty (30) calendar days after the expiration of the initial sixty (60) calendar days.

H. Documentation

1. The Office of Compliance shall document the request in the Office of Compliance tracking database that shall include, but not be limited to:

a. Date of request;

b. Name of person who processed the request; and

c. Date the accounting was released to Member.

2. The Office of Compliance shall maintain a copy of the PHI accounting provided to the Member for ten (10) years from the date the request is received.

I. CalOptima shall provide the Member with the first request for an accounting in any twelve (12) month period at no charge. ~~-~~CalOptima may charge the Member a reasonable, cost-based fee for each future request within the twelve (12) month period, provided that CalOptima informs the Member in advance of the fee, and offers the Member a chance to withdraw, or modify, the request to avoid, or reduce, the fee.

IV. ATTACHMENTS

A. Request for an Accounting of Disclosures Form
B. Response to Request for Accounting of Disclosures

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.3006Δ: Tracking Disclosures of Protected Health Information
F. CalOptima Privacy Program
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. Guide to Medical Privacy and HIPAA, Thompson Publishing Group, 2002, Section 400-Medical Records Privacy Requirements
I. NCQA Standard MED5 Privacy and Confidentiality: Element A: Factor 5-2017
~~I.~~J. Title 45, Code of Federal Regulations (~~C.F.R~~CFR), §164.528

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/01/16: ~~-~~ Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/01/2005	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	04/01/2007	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	01/01/2008	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	02/01/2008	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	07/01/2011	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	07/01/2011	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	01/01/2013	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal OneCare
Revised	01/01/2014	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal OneCare
Revised	06/01/2014	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	11/01/2014	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	11/01/2014	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	09/01/2015	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	09/01/2015	MA.9209	Member Request for Accounting of Disclosures	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3005Δ	Member Request for Accounting of Disclosures	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9209	Member Request for Accounting of Disclosures	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3005Δ	Member Request for Accounting of Disclosures	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: • On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or • Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: • A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. • A person that offers a personal health record to one or more individuals on behalf of a covered entity. • A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Term	Definition
Designated Record Set (DRS)	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: • The medical records and billing records about individuals maintained by or for a covered health care provider; • The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or • Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance audits, health insurance underwriting, premium rating and other activities related to a contact and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Limited Data Set	Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Member	An enrollee-beneficiary of a CalOptima -program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

Policy #:	HH.3005Δ
Title:	**Member Request for Accounting of Disclosures**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/07/17
Last Revised Date:	12/01/17

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

I. PURPOSE

This policy defines the scope of a Member's right to request an accounting of Disclosures made by CalOptima of the Member's Protected Health Information (PHI) created, or maintained, in a Designated Record Set (DRS) by CalOptima or its Business Associates.

II. POLICY

A. Upon a Member's request, CalOptima shall provide an accounting of PHI Disclosures released for a time period not to exceed six (6) years.

1. Disclosures excluded from accounting include Disclosures:

   a. To carry out Treatment, Payment and Health Care Operations;

   b. To individuals of PHI about them;

   c. Incident to a Use or Disclosure otherwise permitted or required;

   d. Pursuant to an authorization;

   e. For the facility's directory or to persons involved in the individual's care or other notification purposes as provided in 45 CFR §164.510;

   f. For national security or intelligence purposes;

   g. To correctional institutions or law enforcement officials;

   h. As part of a limited data set; or

   i. That occurred prior to the compliance date for CalOptima.

B. The Office of Compliance shall track all other Disclosures of PHI not mentioned in Section II.A., in accordance with CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information.

C. Disclosure of PHI is not limited to hard-copy information and may include any information Disclosed by other means, such as verbally, electronic data release, or by facsimile.

D. CalOptima shall temporarily suspend a Member's right to receive an accounting of Disclosures pursuant to a request from a health oversight agency, or law enforcement official if:

1. CalOptima receives a written statement from such agency or official that an accounting to the Member would be reasonably likely to impede the agency's activities, and specifying the time for which such a suspension is required; or

2. A health oversight agency, or law enforcement official, provides a verbal statement to CalOptima, in which case CalOptima shall:

a. Document the statement, including the identity of the agency, or official, making the statement;

b. Temporarily suspend the Member's right to an accounting of Disclosures subject to the statement; and

c. Limit the temporary suspension to no longer than thirty (30) calendar days from the date of the oral statement, unless CalOptima receives a written request for suspension.

III. PROCEDURE

A. A Member may request an accounting of Disclosures of his or her PHI that CalOptima released, in the six (6) years prior to the date of the request (or lesser time, if requested), by submitting a Request for an Accounting of Disclosures Form to the Customer Service Department.

B. The Customer Service Department shall:

1. Provide the Member with a Request for an Accounting of Disclosures Form by U.S. mail, or in person at the CalOptima office; and

2. Assist the Member in completing the form, if necessary.

C. CalOptima's Customer Service Department shall forward all requests to the Privacy Officer, or Designee, who shall process the request.

D. CalOptima shall review a Member's request for an accounting of Disclosure from Members enrolled in a Health Network in coordination with the Health Network, or other Business Associate, as appropriate.

E. A written account of the Disclosures shall include:

1. Disclosures of PHI that occurred during the six (6) years, or shorter time period as designated on the Member's request, prior to the date of the request for an accounting specifying:

    a. The date of the Disclosure;

    b. The name of the entity, or person, who received the PHI, and if known, the address of such entity or person;

    c. A brief description of the PHI Disclosed; and

    d. A brief statement of the purpose of the Disclosure that reasonably informs the individual of the basis for the Disclosure, or in lieu of such statement, a copy of a written request for a Disclosure.

F. If multiple requests were made by the same individual or entity, CalOptima shall provide the information required by Section III.E. for the first Disclosure and the frequency, periodicity, or number of Disclosures made during the accounting period requested by the Member and the date of the last such Disclosure during the accounting period requested by the Member.

G. The Office of Compliance shall act on the Member's request, and:

1. Provide the Member with the PHI accounting within sixty (60) calendar days after the date of request; or

2. If the PHI accounting will not be prepared within the sixty (60) calendar days, communicate to the Member:

    a. The reasons why the PHI accounting will not be prepared within sixty (60) calendar days;

    b. The date in which the PHI accounting will be prepared; and

    c. Complete the request within an additional thirty (30) calendar days after the expiration of the initial sixty (60) calendar days.

H. Documentation

1. The Office of Compliance shall document the request in the Office of Compliance tracking database that shall include, but not be limited to:

    a. Date of request;

    b. Name of person who processed the request; and

    c. Date the accounting was released to Member.

2. The Office of Compliance shall maintain a copy of the PHI accounting provided to the Member for ten (10) years from the date the request is received.

I. CalOptima shall provide the Member with the first request for an accounting in any twelve (12) month period at no charge. CalOptima may charge the Member a reasonable, cost-based fee for

each future request within the twelve (12) month period, provided that CalOptima informs the Member in advance of the fee, and offers the Member a chance to withdraw, or modify, the request to avoid, or reduce, the fee.

IV. ATTACHMENTS

A. Request for an Accounting of Disclosures Form
B. Response to Request for Accounting of Disclosures

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
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G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. Guide to Medical Privacy and HIPAA, Thompson Publishing Group, 2002, Section 400-Medical Records Privacy Requirements
I. NCQA Standard MED5 Privacy and Confidentiality: Element A: Factor 5-2017
J. Title 45, Code of Federal Regulations (CFR), §164.528

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
B. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Effective	06/01/2005	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	04/01/2007	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	01/01/2008	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	02/01/2008	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	07/01/2011	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal

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Revised	07/01/2011	MA.9209	Member Request for Accounting of Disclosures	OneCare
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Revised	01/01/2014	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal OneCare
Revised	06/01/2014	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	11/01/2014	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	11/01/2014	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	09/01/2015	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	09/01/2015	MA.9209	Member Request for Accounting of Disclosures	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3005Δ	Member Request for Accounting of Disclosures	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9209	Member Request for Accounting of Disclosures	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3005Δ	Member Request for Accounting of Disclosures	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: • On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or • Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: • A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. • A person that offers a personal health record to one or more individuals on behalf of a covered entity. • A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Term	Definition
Designated Record Set (DRS)	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: • The medical records and billing records about individuals maintained by or for a covered health care provider; • The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or • Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance audits, health insurance underwriting, premium rating and other activities related to a contact and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Limited Data Set	Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Member	An enrollee-beneficiary of a CalOptima program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Request for an Accounting of Disclosures Form

Date of Request: _____

Member Name: _____ Date of Birth: _____

Member CIN: _____ Telephone Number: _____

I would like an accounting or record of how my Protected Health Information (PHI) was disclosed by CalOptima, as required by federal regulations. I understand that CalOptima does not have to tell me about the following types of disclosures:

1. Disclosures for purposes of Treatment, Payment and Health Care Operations.
2. Disclosures to me or authorized by me to another person(s).
3. Disclosures to persons involved in my care.
4. Disclosures to State or Federal health oversight agencies
5. Disclosures made prior to April 14, 2003.

I also understand that my right to a record of some, or all disclosures, may be suspended by the government under limited circumstances.

I understand that CalOptima must give me the record of disclosures within 60 calendar days, or give notice to me that an extra 30 calendar days (or less) is needed to prepare it.

I understand I am allowed one (1) free record or accounting of disclosures for every 12-month period. I may be charged a fee if I request more than one accounting of disclosures within the same 12-month period.

For more information about your privacy rights, please visit our website at www.caloptima.org or call CalOptima's Customer Service Department toll-free at 1-888-587-8088. Members with hearing or speech impairments can call our TDD line at 1-714-246-8523. We have staff who can speak your language.

I would like a record of disclosures that covers the following time period:

From: _____ To: _____
Note: The time period may not be longer than six (6) years, and may not include dates before April 14, 2003.

I would like the record of disclosures in the following form:

☐ On paper, to the following address:

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

☐ Electronically, sent through a secure e-mail to: _____

Member Signature: _____

If Authorized Representative, please complete the section below and provide documentation:

Print Name: _____ Relationship to Member: _____

[date]

VIA ELECTRONIC MAIL

[name]
[address]
[city], CA [zip]

Re: Request for Accounting of Disclosures

Dear Mr./Ms. [insert last name]:

We received your request for an accounting of disclosures of your Protected Health Information (PHI) form on [date]. Your form indicates that you requested an accounting of disclosures for [date range]. [Our records show the following PHI disclosures have been made:] Our records show that your PHI was not disclosed for purposes other than the ones listed below, which describes the information that health care organizations are not required to release under the Health Insurance Portability and Accountability Act (HIPAA) regulation.

CalOptima is not required to provide you with an accounting of the following types of disclosures:

1. Disclosures for purposes of Treatment, Payment and Health Care Operations.
2. Disclosures to me or authorized by me to another person(s).
3. Disclosures to persons involved in my care.
4. Disclosures to State or Federal health oversight agency.
5. Disclosures made prior to April 14, 2003.

A copy of your Request for an Accounting of Disclosures Form is enclosed.

Please feel free to contact me at (714) 246-[XXXX], if you have any questions regarding the information contained in this letter.

Sincerely,

Compliance Analyst
Office of Compliance

Encl.: Accounting of Disclosures Form

Policy #:	HH.3015Δ
Title:	**Member Authorization for the Use and Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	~~05/01~~12/07/17
Last Revised Date:	~~05/01~~12/07/17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy describes the circumstances and process for obtaining a Member's (or from their Personal Representative) Authorization for the Use and Disclosure of a Member's Protected Health Information (PHI).

II. POLICY

A. CalOptima shall only Use or Disclose a Member's PHI pursuant to a written Authorization from the Member, or the Member's ~~Authorized~~Personal Representative, unless otherwise permitted, or required, by the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state laws.

B. CalOptima will not condition Treatment, Payment, enrollment, or benefits eligibility on an individual granting an Authorization.

C. CalOptima shall obtain, review, and confirm that it has a valid Authorization from the Member, or the Member's ~~Authorized~~Personal Representative, in accordance with HIPAA, other applicable federal and state laws, and this policy prior to a Use or Disclosure of PHI that requires an ~~Authorization~~authorization.

D. CalOptima may Use and ~~Disclosure~~Disclose a Member's PHI ~~in the following circumstances~~ without a Member's Authorization ~~in the following circumstances:~~ for Treatment, Payment~~, or Health Care~~ and Healthcare Operations ~~in compliance with~~as permitted by HIPAA and other applicable federal and state laws ~~to the extent that they are more protective~~and CalOptima Policy HH.3011Δ: Uses and Disclosures of ~~the Member's privacy.~~Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations..

E. Uses and Disclosures involving Member PHI that has been properly "De-Identified," pursuant to the requirements in Title 45, Code of Federal Regulations, Section 164.514, do not require a Member's Authorization.

III. PROCEDURE

A. All valid authorizations shall contain specified core elements and requirements, in accordance with Title 45, Code of Federal Regulations, Section 164.508(c~~).~~) and California Civil Code, Section 56.11. CalOptima's Authorization Form for Release of PHI contains the required elements in compliance with Title 45, Code of Federal Regulations, Section 164.508(c~~):~~) and California Civil Code, Section 56.11:

1. Is handwritten by the person who signs it or is in a typeface no smaller than fourteen (14)-point type.

~~1.~~2. A description of the information to be Used or Disclosed;

~~2.~~3. The name of the person or organization that will Use or Disclose the PHI;

~~3.~~4. The name of the person or organization that will receive the PHI;

~~4.~~5. ~~A description of~~Identifies the ~~purpose~~uses and limitations on uses for which the PHI will be ~~used~~disclosed (except for requests by Member, which can indicate "at Member's request" without further explanation);

6. The specific expiration date;

~~5.~~7. Member's or ~~event;~~Member's Personal Representative's signature and the date. If the authorization is signed by a Personal Representative of the individual, a description of such representative's authority to act for the individual must also be provided. (*e.g.* parent, power of attorney for health care, court-appointed guardian, etc.); and

~~6. Statement that further Use or Disclosure of the PHI is prohibited unless another authorization is obtained from the Member or such Use or Disclosure is specifically required or permitted by law.~~

8. In addition to the requirements above, the following statements must also be included in the authorization;

~~7.~~a. A statement that the Member has the right to revoke the authorization, in writing, and any exceptions to this right;

~~8. Member's signature and the date (if signed by Member Personal Representative, state relationship); and~~

~~9. Additional elements that apply if authorization is requested by CalOptima;~~

~~a.~~b. A statement that CalOptima will not condition Treatment, or Payment, on the Member signing the Authorization request;

c. A statement informing the member about the potential for information to be redisclosed and no longer protected by the state or federal privacy rule;

~~b.~~d. A statement that the Member can refuse to sign the Authorization;

~~c.~~e. A statement that the Member is entitled to a copy of the signed Authorization. A copy of the signed Authorization must be given to the Member; or

~~d.~~f. A statement when any Disclosure will result in either direct, or indirect, Payment to CalOptima from the receiver of the PHI.

B. The Authorization must be completed and must be signed by the person with authority to authorize Use or Disclosure of PHI (i.e., the Member or their ~~Authorized~~Personal Representative).

C. All Uses and Disclosures made pursuant to an Authorization must be consistent with the Authorization.

~~D.~~K. ~~Authorization shall be obtained from the Member for any Use or Disclosure of PHI for Marketing, except when:~~

~~1. Face-to-face communication is made by CalOptima to the Member; or~~

~~2. A promotional gift of nominal value is provided by CalOptima.~~

~~E.~~D. An Authorization shall be considered invalid if the document submitted contains any of the following defects:

~~1.~~7. The expiration date has passed, or the expiration date is known by CalOptima to have passed;

~~2.~~8. The Authorization does not contain all the required elements;

~~3.~~9. The Authorization is known by CalOptima to have been revoked;

~~4.~~10. The Authorization is combined with any other document in a manner that is not permitted under the privacy standard; ~~or~~

11. The signature serves some purpose in addition to the authorization to disclose PHI; or

~~5.~~12. The Authorization contains material information known by CalOptima to be false.

~~F.~~E. CalOptima staff shall verify the identity of the ~~Authorized~~Personal Representative, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information.

G. Revocation of Authorization

1. A Member may revoke an Authorization at any time by writing to CalOptima and requesting that the Authorization be revoked.

2. The revocation will not apply to those Uses or Disclosures made with reliance on the Authorization prior to the receiving the request to revoke the Authorization.

H. All signed Authorization and revocation notices are retained on file for ten (10) years from the date the documents are received by CalOptima.

I. CalOptima shall mail a HIPAA Authorization for Release of Information Form to Members requesting disclosure of PHI when such form is required by HIPAA privacy regulations.

1. Upon receipt of signed and completed form via fax, or mail, the CalOptima Privacy Officer, or Designee, shall review, approve, or deny, and disclose requested information when appropriate, per the signed form.

K. CalOptima shall obtain Authorization from the Member for any Use or Disclosure of psychotherapy notes except in the following situations:

1. Use by the originator of the psychotherapy notes for Treatment;

2. Use or Disclosure by a covered entity's own training program for students, trainees, or practitioners in mental health, under supervision, to improve skills;

3. Use by a Provider for purposes of diagnosis, or Treatment, of the Member;

4. Use or Disclosure by a covered entity to defend itself in a legal action, or other proceeding, brought by the Member; or

5. Evaluation, or oversight, of the practitioner creating the psychotherapy notes.

L. Authorization shall be obtained from the Member for any Use or Disclosure of PHI for Marketing, except when:

1. Face-to-face communication is made by CalOptima to the Member; or

2. The communication is in the form of a promotional gift of nominal value provided by CalOptima.

IV. ATTACHMENTS

A. Authorization for Release of Protected Health Information (PHI)
B. Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form
C. HIPAA Authorization Checklist

V. REFERENCES

A. California Civil Code, §§56.10(c), 56.11(b) and 56.104
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement

F. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information
G. CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information
H. CalOptima Policy HH.3011Δ: Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations
~~H.~~I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~I.~~J. NCQA Standard MED5 Privacy and Confidentiality: Factor B – 2017
~~J.~~K. Title 22, Code of California Regulations (C.C.R.), §51009
~~K.~~L. Title 45, Code of Federal Regulations (C.F.R.), §§164.502(a)(iv), 164.506(a), and 164.508, 164.512
~~L.~~M. Welfare & Institutions Code, §14100.2

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/01/16: ~~–~~ Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Effective	06/01/2005	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	04/01/2007	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2008	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	02/01/2008	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	09/01/2009	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Revised	09/01/2009	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	01/01/2010	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2011	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2013	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	05/01/2013	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	05/01/2013	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare
Revised	08/01/2013	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Revised	01/01/2014	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	06/01/2014	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	09/01/2014	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare
Revised	11/01/2014	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	11/01/2014	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	09/01/2015	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	09/01/2015	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Revised	09/01/2015	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/01/2016	HH.3015Δ	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Retired	12/01/2016	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare OneCare Connect PACE
Reviewed	05/01/2017	HH.3015Δ	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/01/2017	HH.3015Δ	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorization	Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code Section 14100.2.
~~Authorized Representative~~	~~Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.~~
De-identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Term	Definition
Marketing	Has the meaning given such term in 45, Code of Federal Regulations, Section 164.501. 1. Except as provided in paragraph (2) of this definition, marketing means to make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. 2. Marketing does not include a communication made: i. To provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual, only if any financial remuneration received by the covered entity in exchange for making the communication is reasonably related to the covered entity's cost of making the communication. ii. For the following treatment and health care operations purposes, except where the covered entity receives financial remuneration in exchange for making the communication: a. For treatment of an individual by a health care provider, including case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual; b. To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entity making the communication, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; or c. For case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions to the extent these activities do not fall within the definition of treatment.
Member	A beneficiary who is enrolled in a CalOptima Program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Payment	Activities carried out by CalOptima including: 1. Determination eligibility, risk adjustments based on the Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification or charges; and 3. Utilization review activities including pre-certification, pre-authorization, concurrent, or retrospective review of services.

Term	Definition
Personal Representative	Has the meaning in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009Δ: Access, Use, and Disclosure of PHI to a Member's Personal Representative.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI~~) ONLY~~)

HIPAA privacy regulations ~~require~~require you to complete ~~all~~ **ALL** ~~required~~ sections of this form to authorize CalOptima to release your protected health information (PHI) to another person or ~~entity~~agency. This form is **ONLY** for release of information. It will not give the authorized representative the ability to make health care changes on the member's behalf in any way.~~This form is intended **ONLY** for release of information.~~

SECTION A: Member Information~~Authorizing Release of PHI *REQUIRED*~~

Last~~Member's~~ Name: _____ ~~Member~~ First Name:~~CIN:~~ _____

CIN: _____ Date of Birth: _____
mm/dd/yyyy

Address: _____
Street/Unit Number *City* *ST* *Zip Code*

Best ~~Phone~~ phone ~~(Home):~~number to contact you at: ~~Member Date of Birt~~Phone ~~(Cellh):~~

SECTION B: Information that Can Be Released

I allow the following information to be released by CalOptima:

☐ Any and all information pertaining to my ~~protected health information~~PHI; OR
☐ Limit the use and disclosure of ~~information~~PHI to the following (Please specify):
_____

NOTE: The following types of information will not be released unless specifically authorized. I specifically authorize the release of the following health information (initials required if any of the following boxes are checked):

Mental health treatment information Initial: _____

Alcohol / drug treatment information Initial: _____

SECTION C: Purpose of this Authorization

~~This protected health information is being disclosed for the following purpose(s) (Please select one):~~Please describe the purpose or reason for sharing or using PHI.

☐ ~~At the request of the member~~Personal Use

☐ Insurance ☐~~-~~

~~Other (Please specify.):~~

☐ Legal

☐ Other (Please specify.):~~_____~~ _____

SECTION ~~D~~DB: Person(s) or ~~Entity~~Agency(ies) Authorized to Receive ~~this Information~~PHI ~~*REQUIRED*~~

~~Please enter the person(s) or organization who will receive member's PHI. This information may be disclosed to, and used by, the following person(s) or entity(entity (ies).~~ By filling out Section D, I am letting CalOptima use or share my PHI with the person or agency below. I know this authorization starts when I sign and return this form.

The representative receiving the information must be 18 years of age or older.

Representative/Agency's~~'s~~ Name(s): _____

Relationship to Member: _____ Phone: _____

~~SECTION C: Information that Can Be Released *REQUIRED*~~

~~**I allow the following information to be released by CalOptima:**~~

~~☐ Any and all information pertaining to my health information; OR~~

~~☐ Only the following records or types of health information (Please specify.):~~

_____

~~SECTION D: Purpose of this Authorization *REQUIRED*~~

~~This protected health information is being disclosed for the following purpose(s) (Please select one.):~~

~~☐ At the request of the member~~

~~☐ Other (Please specify.):~~ _____

SECTION E: My Rights

- ~~I understand that I have the right to withdraw this authorization, in writing, at any time by sending written notification to: CalOptima, Attn: Customer Service Department.~~
- You may stop this authorization, in writing, at any time by sending written notification to: CalOptima, Attn: Enrollment & Reconciliation Department.

SECTION E: My Rights Continued

- ~~I also understand that my revocation is not effective to the extent that the persons I have authorized to disclose my protected health information have acted in reliance upon this authorization prior to receipt of the revocation.~~Sending a letter to stop this authorization will not change how CalOptima used or shared my PHI before getting my letter.
- ~~I understand my authorization to release this information will not affect my eligibility or enrollment status, or any treatment or benefit payment decisions. I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy laws.~~The person or agency who gets my PHI from CalOptima may show it to others. In this case, your PHI may no longer be protected by HIPAA Privacy Rules.
- ~~I release CalOptima from any liability associated with releasing this information to the person/agency named above. I understand that I may have the right under federal or state law to inspect or copy the protected health information to be disclosed.~~You do not have to fill out or sign this form. Not filling out this form will not affect your ability to obtain benefits, receive payment of your claims or otherwise affect your eligibility with CalOptima in any way.
- ~~I understand I have the right to refuse to sign this authorization.~~
- You have the right to look at or get a copy of your PHI that is being used or shared by this authorization.

SECTION F: Expiration Date of Authorization

By filling out Section F, I am letting CalOptima know when my PHI can no longer be used or shared with others. **If a specific date is not provided, this authorization will expire one (1) year after the signature date:**

This authorization expires on: _____

mm/dd/yyyy

_____

~~SECTION F: Expiration Date of Authorization *REQUIRED*~~

This authorization will remain in effect until the date or event specified below becomes effective on signature date and will end on: . If no end date is indicated or event is specified, this authorization will automatically expire three (3) years from after the date of signature: signature date.

☐ This authorization expires on: _____ ; **OR**

mm/dd/yyyy

☐ Upon the following event (must relate to member or to the purpose of this authorization):

_____

SECTION G: Signature
REQUIRED

By signing below, I acknowledge understand that I have the right to get receiving a copy of this authorization. Please be advised that in order to process your request, a copy of a valid valid, government-issued photo identification (ID) with your signature must be included with your request form or your signature must be notarized. I have read this form and know what it means.

Signature**:** _____ Date: _____
(Member/Legal Representative) *mm/dd/yyyy*

If signed by a person other than the member, indicate relationship:
If signed by a person other than the member p Print
n Name: _____
(Legal Representative)
If signed by a person other than the member, description of representative's authority to act for the individual:

_____
Please provide a description of representative's authority to act for the individual:

_____

* CalOptima reserves the right to request legal documentation (e.g. birth certificate, court order, etc.) from the Legal Representative signing on behalf of a Member.

Please submit the completed form to:
CalOptima
505 City Parkway West
Orange, CA 92868
Fax: (714) 338-3104
STOP

Please return this form to the address or fax number listed at the bottom of this page.

For CalOptima Use Only:

~~Staff Name:~~

~~Date Verified:~~

Staff Name: _____ How was identity verified? ~~Date Verified:~~ In person/Phone

Signature: Date verified:

Instruction Sheet for CalOptima
Health Insurance Portability and Accountability Act (HIPAA) Authorization
for Release of Protected Health Information (PHI)

SECTION A: MEMBER AUTHORIZING RELEASE

This section applies to the member who is asking for the release of his or her information to another person or organization. Please complete all items of information in this section.

SECTION B: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the name(s) of the person(s) or organization(s) that you are authorizing to access your PHI. For example, if you are authorizing your spouse, adult child, or any other individual to obtain your PHI, enter his/her name in these spaces. If you are authorizing an organization (such as a broker, law firm, insurance agency, etc.) to obtain your PHI, enter the specific name of the organization in these spaces. **Examples include:** ***"Dr. John Smith" or "Mary Doe (spouse)."*** Indicate how the person(s) or organization(s) is related to you (for example, spouse, adult child, etc.) and provide their phone number.

SECTION C: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release. Be specific regarding the types of documents you are authorizing for release. For example, if you are authorizing an individual to obtain PHI related to a recent medical event, specify the date of the medical event, the types of documents you are requesting (e.g. billing records, pre-authorization records, or pharmacy records) and state any types of records you would like to exclude.

SECTION D: PURPOSE OF THIS AUTHORIZATION

Select the reason(s) you've asked for the release of your information. If you have a specific reason, please fill in under "**Other**" and indicate the reason. For example, if you only want the person(s) or organization(s) you are authorizing to receive your protected health information for a pending claims appeal, you would enter ***"To appeal a claim determination"*** or something similar in that block.

SECTION E: EXPIRATION DATE OF AUTHORIZATION

Check the first box if you want the authorization to end on a certain date. Enter in the date of expiration. Check the second box if you wish for the authorization to expire on a certain event, for example, "***one year from my signature date***."

SECTION F: REVIEW AND APPROVAL

If you are the member, sign your name and enter the date you signed the form. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.**

If you are the member's personal representative, sign your name, enter the date you signed the form and indicate your representative relationship. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.** You **must** also provide us with a copy of the legal documentation indicating you are the authorized personal representative of the member.

- Examples of legal documents:
  - **Power of Attorney for Health Care~~, General or Durable Power of Attorney~~** — this document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
  - **Legal Guardianship** — this is when the court appoints someone to care for another person.
  - **Conservatorship of the Person** — this happens when the court appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
  - **Executor of Estate** — this type of document would be used when the person who is being represented has died.

Please keep a copy of the form for your records.

~~Policy #HH3015~~ ~~Authorization for Release of Protected Health Information~~

~~Attachment C:~~ HIPAA Authorization Checklist

The following checklist is utilized to assess the validity of the authorization submitted with requests for release of information on a **non-CalOptima** HIPAA Authorization for Release of Information. The authorization must contain the following core elements and required statements.

#	**Requirements for Authorization to Disclose Patient Health Information or Records (45 CFR, 164.508(c) and California Civil Code, Section 56.11)**	✓
1	Authorization provides a description of the ~~patient's~~ member's protected health information to be used or disclosed that identifies the information in a specific and meaningful fashion.	
2	Authorization identifies CalOptima as authorized to make the disclosure.	
3	Authorization identifies the person's name or organization authorized to whom CalOptima may make the disclosure.	
4	Authorization identifies the ~~purpose~~ uses and limitations of uses ~~of~~ for the disclosure. The statement "at the request of the ~~patient~~member" is a sufficient description ~~of the purpose~~for the use and disclosure when a ~~patient~~ member initiates the authorization and does not, or elects not to, provide a statement of the purpose.	
5	Authorization identifies a specific ~~n~~ expiration date. ~~or an expiration event that relates to the patient or the purpose of the use or disclosure.~~	
6	Authorization contains the signature of the ~~patient~~ member or ~~patient's~~ member's authorized legal representative.	
7	~~If signed by an authorized legal representative,~~ If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided. (*e.g.* parent, power of attorney for health care, court-appointed guardian, etc)~~the authorization identifies the relationship of that person to the patient member~~	
8	Authorization includes the date on which the authorization is signed.	
9	Authorization contains a statement informing the ~~patient~~ member regarding the right to revoke the authorization in writing and a description how to do so.	
10	Authorization contains a statement informing the ~~patient~~ member about the organization's ability or inability to condition treatment, payment, enrollment or eligibility for benefits.	
11	Authorization contains a statement informing the ~~patient~~ member about the potential for information to be re-disclosed and no longer protected by the state or federal privacy rule.	
12	Authorization contains a statement informing the member that he or she has the right to receive a copy of the signed authorization.	
~~12~~	Authorization is written in plain language	
14	Is handwritten by the person who signs it or is in a typeface no smaller than 14-point type.	

Rev. 11/2017~~. 09/2017~~

Back to Agenda

15	The signature serves no purpose other than authorizing the disclosure of PHI	

Policy #:	HH.3015Δ
Title:	**Member Authorization for the Use and Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/07/17
Last Revised Date:	12/07/17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the circumstances and process for obtaining a Member's (or from their Personal Representative) Authorization for the Use and Disclosure of a Member's Protected Health Information (PHI).

II. POLICY

A. CalOptima shall only Use or Disclose a Member's PHI pursuant to a written Authorization from the Member, or the Member's Personal Representative, unless otherwise permitted, or required, by the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state laws.

B. CalOptima will not condition Treatment, Payment, enrollment, or benefits eligibility on an individual granting an Authorization.

C. CalOptima shall obtain, review, and confirm that it has a valid Authorization from the Member, or the Member's Personal Representative, in accordance with HIPAA, other applicable federal and state laws, and this policy prior to a Use or Disclosure of PHI that requires an authorization.

D. CalOptima may Use and Disclose a Member's PHI without a Member's Authorization for Treatment, Payment and Healthcare Operations as permitted by HIPAA and other applicable federal and state laws and CalOptima Policy HH.3011Δ: Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations.

E. Uses and Disclosures involving Member PHI that has been properly "De-Identified," pursuant to the requirements in Title 45, Code of Federal Regulations, Section 164.514, do not require a Member's Authorization.

III. PROCEDURE

A. All valid authorizations shall contain specified core elements and requirements, in accordance with Title 45, Code of Federal Regulations, Section 164.508(c) and California Civil Code, Section 56.11. CalOptima's Authorization Form for Release of PHI contains the required elements in compliance

with Title 45, Code of Federal Regulations, Section 164.508(c) and California Civil Code, Section 56.11:

1. Is handwritten by the person who signs it or is in a typeface no smaller than fourteen (14)-point type.

2. A description of the information to be Used or Disclosed;

3. The name of the person or organization that will Use or Disclose the PHI;

4. The name of the person or organization that will receive the PHI;

5. Identifies the uses and limitations on uses for which the PHI will be disclosed (except for requests by Member, which can indicate "at Member's request" without further explanation);

6. The specific expiration date;

7. Member's or Member's Personal Representative's signature and the date. If the authorization is signed by a Personal Representative of the individual, a description of such representative's authority to act for the individual must also be provided. (*e.g.* parent, power of attorney for health care, court-appointed guardian, etc.); and

8. In addition to the requirements above, the following statements must also be included in the authorization;

    a. A statement that the Member has the right to revoke the authorization, in writing, and any exceptions to this right;

    b. A statement that CalOptima will not condition Treatment, or Payment, on the Member signing the Authorization request;

    c. A statement informing the member about the potential for information to be redisclosed and no longer protected by the state or federal privacy rule;

    d. A statement that the Member can refuse to sign the Authorization;

    e. A statement that the Member is entitled to a copy of the signed Authorization. A copy of the signed Authorization must be given to the Member; or

    f. A statement when any Disclosure will result in either direct, or indirect, Payment to CalOptima from the receiver of the PHI.

B. The Authorization must be completed and must be signed by the person with authority to authorize Use or Disclosure of PHI (i.e., the Member or their Personal Representative).

C. All Uses and Disclosures made pursuant to an Authorization must be consistent with the Authorization.

D. An Authorization shall be considered invalid if the document submitted contains any of the following defects:

7. The expiration date has passed, or the expiration date is known by CalOptima to have passed;

8. The Authorization does not contain all the required elements;

9. The Authorization is known by CalOptima to have been revoked;

10. The Authorization is combined with any other document in a manner that is not permitted under the privacy standard;

11. The signature serves some purpose in addition to the authorization to disclose PHI; or

12. The Authorization contains material information known by CalOptima to be false.

E. CalOptima staff shall verify the identity of the Personal Representative, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information.

G. Revocation of Authorization

1. A Member may revoke an Authorization at any time by writing to CalOptima and requesting that the Authorization be revoked.

2. The revocation will not apply to those Uses or Disclosures made with reliance on the Authorization prior to the receiving the request to revoke the Authorization.

H. All signed Authorization and revocation notices are retained on file for ten (10) years from the date the documents are received by CalOptima.

I. CalOptima shall mail a HIPAA Authorization for Release of Information Form to Members requesting disclosure of PHI when such form is required by HIPAA privacy regulations.

1. Upon receipt of signed and completed form via fax, or mail, the CalOptima Privacy Officer, or Designee, shall review, approve, or deny, and disclose requested information when appropriate, per the signed form.

K. CalOptima shall obtain Authorization from the Member for any Use or Disclosure of psychotherapy notes except in the following situations:

1. Use by the originator of the psychotherapy notes for Treatment;

2. Use or Disclosure by a covered entity's own training program for students, trainees, or practitioners in mental health, under supervision, to improve skills;

3. Use by a Provider for purposes of diagnosis, or Treatment, of the Member;

4. Use or Disclosure by a covered entity to defend itself in a legal action, or other proceeding, brought by the Member; or

5. Evaluation, or oversight, of the practitioner creating the psychotherapy notes.

L. Authorization shall be obtained from the Member for any Use or Disclosure of PHI for Marketing, except when:

1. Face-to-face communication is made by CalOptima to the Member; or

2. The communication is in the form of a promotional gift of nominal value provided by CalOptima.

IV. ATTACHMENTS

A. Authorization for Release of Protected Health Information (PHI)
B. Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form
C. HIPAA Authorization Checklist

V. REFERENCES

A. California Civil Code, §§56.10(c), 56.11(b) and 56.104
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information
G. CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information
H. CalOptima Policy HH.3011Δ: Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations
I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. NCQA Standard MED5 Privacy and Confidentiality: Factor B – 2017
K. Title 22, Code of California Regulations (C.C.R.), §51009
L. Title 45, Code of Federal Regulations (C.F.R.), §§164.502(a)(iv), 164.506(a), and 164.508, 164.512
M. Welfare & Institutions Code, §14100.2

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
B. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Effective	06/01/2005	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	04/01/2007	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2008	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	02/01/2008	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	09/01/2009	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Revised	09/01/2009	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare
Revised	01/01/2010	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2011	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2013	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	05/01/2013	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	05/01/2013	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare
Revised	08/01/2013	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Revised	01/01/2014	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	06/01/2014	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2014	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare
Revised	11/01/2014	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	11/01/2014	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	09/01/2015	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	09/01/2015	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Revised	09/01/2015	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3015Δ	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Retired	12/01/2016	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare OneCare Connect PACE
Reviewed	05/01/2017	HH.3015Δ	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/01/2017	HH.3015Δ	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorization	Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code Section 14100.2.
De-identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Term	Definition
Marketing	Has the meaning given such term in 45, Code of Federal Regulations, Section 164.501. 1. Except as provided in paragraph (2) of this definition, marketing means to make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. 2. Marketing does not include a communication made: i. To provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual, only if any financial remuneration received by the covered entity in exchange for making the communication is reasonably related to the covered entity's cost of making the communication. ii. For the following treatment and health care operations purposes, except where the covered entity receives financial remuneration in exchange for making the communication: a. For treatment of an individual by a health care provider, including case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual; b. To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entity making the communication, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; or c. For case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions to the extent these activities do not fall within the definition of treatment.
Member	A beneficiary who is enrolled in a CalOptima Program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Payment	Activities carried out by CalOptima including: 1. Determination eligibility, risk adjustments based on the Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification or charges; and 3. Utilization review activities including pre-certification, pre-authorization, concurrent, or retrospective review of services.

Term	Definition
Personal Representative	Has the meaning in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009Δ: Access, Use, and Disclosure of PHI to a Member's Personal Representative.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

HIPAA privacy regulations require you to complete **ALL** sections of this form to authorize CalOptima to release your protected health information (PHI) to another person or agency. This form is **ONLY** for release of information. It will not give the authorized representative the ability to make health care changes on the member's behalf in any way.

SECTION A: Member Information

Last Name: _____ First Name: _____

CIN: _____ Date of Birth: _____
mm/dd/yyyy

Address: _____
Street/Unit Number *City* *ST* *Zip Code*

Best phone number to contact you at: _____

SECTION B: Information that Can Be Released

I allow the following information to be released by CalOptima:

☐ Any and all information pertaining to my PHI; OR

☐ Limit the use and disclosure of PHI to the following (Please specify):

NOTE: The following types of information will not be released unless specifically authorized. I specifically authorize the release of the following health information (initials required if any of the following boxes are checked):

Mental health treatment information Initial:_____

Alcohol / drug treatment information Initial:_____

SECTION C: Purpose of this Authorization

Please describe the purpose or reason for sharing or using PHI.

☐ Personal Use ☐ Legal

☐ Insurance ☐ Other (Please specify.):_____

SECTION D: Person(s) or Agency(ies) Authorized to Receive PHI

By filling out Section D, I am letting CalOptima use or share my PHI with the person or agency below. I know this authorization starts when I sign and return this form. The representative receiving the information must be 18 years of age or older.

Representative/Agency's Name(s): _____

Relationship to Member: _____ Phone: _____

SECTION E: My Rights

- You may stop this authorization, in writing, at any time by sending written notification to: CalOptima, Attn: Enrollment & Reconciliation Department.

SECTION E: My Rights Continued

- Sending a letter to stop this authorization will not change how CalOptima used or shared my PHI before getting my letter.
- The person or agency who gets my PHI from CalOptima may show it to others. In this case, your PHI may no longer be protected by HIPAA Privacy Rules.
- You do not have to fill out or sign this form. Not filling out this form will not affect your ability to obtain benefits, receive payment of your claims or otherwise affect your eligibility with CalOptima in any way.
- You have the right to look at or get a copy of your PHI that is being used or shared by this authorization.

SECTION F: Expiration Date of Authorization

By filling out Section F, I am letting CalOptima know when my PHI can no longer be used or shared with others. **If a specific date is not provided, this authorization will expire one (1) year after the signature date:**

This authorization expires on: _____
mm/dd/yyyy

SECTION G: Signature

By signing below, I understand that I have the right to get a copy of this authorization. Please be advised that in order to process your request, a copy of valid, government-issued identification (ID) must be included with your request form or your signature must be notarized. I have read this form and know what it means.

Signature**:** _____ Date: _____
(Member/Legal Representative) *mm/dd/yyyy*

If signed by a person other than the member print name: _____
(Legal Representative)

Please provide a description of representative's authority to act for the individual:

* CalOptima reserves the right to request legal documentation (e.g. birth certificate, court order, etc.) from the Legal Representative signing on behalf of a Member.

STOP

Please return this form to the address or fax number listed at the bottom of this page.

For CalOptima Use Only:

Staff Name: _____ How was identity verified? In person/Phone

Signature: Date verified:

Instruction Sheet for CalOptima
Health Insurance Portability and Accountability Act (HIPAA) Authorization
for Release of Protected Health Information (PHI)

SECTION A: MEMBER AUTHORIZING RELEASE

This section applies to the member who is asking for the release of his or her information to another person or organization. Please complete all items of information in this section.

SECTION B: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the name(s) of the person(s) or organization(s) that you are authorizing to access your PHI. For example, if you are authorizing your spouse, adult child, or any other individual to obtain your PHI, enter his/her name in these spaces. If you are authorizing an organization (such as a broker, law firm, insurance agency, etc.) to obtain your PHI, enter the specific name of the organization in these spaces. **Examples include:** ***"Dr. John Smith" or "Mary Doe (spouse)."*** Indicate how the person(s) or organization(s) is related to you (for example, spouse, adult child, etc.) and provide their phone number.

SECTION C: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release. Be specific regarding the types of documents you are authorizing for release. For example, if you are authorizing an individual to obtain PHI related to a recent medical event, specify the date of the medical event, the types of documents you are requesting (e.g. billing records, pre-authorization records, or pharmacy records) and state any types of records you would like to exclude.

SECTION D: PURPOSE OF THIS AUTHORIZATION

Select the reason(s) you've asked for the release of your information. If you have a specific reason, please fill in under "**Other**" and indicate the reason. For example, if you only want the person(s) or organization(s) you are authorizing to receive your protected health information for a pending claims appeal, you would enter ***"To appeal a claim determination"*** or something similar in that block.

SECTION E: EXPIRATION DATE OF AUTHORIZATION

Check the first box if you want the authorization to end on a certain date. Enter in the date of expiration. Check the second box if you wish for the authorization to expire on a certain event, for example, "***one year from my signature date***."

SECTION F: REVIEW AND APPROVAL

If you are the member, sign your name and enter the date you signed the form. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.**

If you are the member's personal representative, sign your name, enter the date you signed the form and indicate your representative relationship. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.** You **must** also provide us with a copy of the legal documentation indicating you are the authorized personal representative of the member.

- Examples of legal documents:
    - **Power of Attorney for Health Care**— this document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
    - **Legal Guardianship** — this is when the court appoints someone to care for another person.
    - **Conservatorship of the Person** — this happens when the court appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
    - **Executor of Estate** — this type of document would be used when the person who is being represented has died.

Please keep a copy of the form for your records.

HIPAA Authorization Checklist

The following checklist is utilized to assess the validity of the authorization submitted with requests for release of information on a **non-CalOptima** HIPAA Authorization for Release of Information. The authorization must contain the following core elements and required statements.

#	**Requirements for Authorization to Disclose Patient Health Information or Records (45 CFR, 164.508(c) and California Civil Code, Section 56.11)**	☐
1	Authorization provides a description of the member's protected health information to be used or disclosed that identifies the information in a specific and meaningful fashion.	
2	Authorization identifies CalOptima as authorized to make the disclosure.	
3	Authorization identifies the person's name or organization authorized to whom CalOptima may make the disclosure.	
4	Authorization identifies the uses and limitations of uses for the disclosure. The statement "at the request of the member" is a sufficient description for the use and disclosure when a member initiates the authorization and does not, or elects not to, provide a statement of the purpose.	
5	Authorization identifies a specific expiration date.	
6	Authorization contains the signature of the member or member's authorized legal representative.	
7	If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided. (*e.g.* parent, power of attorney for health care, court-appointed guardian, etc.)	
8	Authorization includes the date on which the authorization is signed.	
9	Authorization contains a statement informing the member regarding the right to revoke the authorization in writing and a description how to do so.	
10	Authorization contains a statement informing the member about the organization's ability or inability to condition treatment, payment, enrollment or eligibility for benefits.	
11	Authorization contains a statement informing the member about the potential for information to be re-disclosed and no longer protected by the state or federal privacy rule.	
12	Authorization contains a statement informing the member that he or she has the right to receive a copy of the signed authorization.	
13	Authorization is written in plain language	
14	Is handwritten by the person who signs it or is in a typeface no smaller than 14-point type.	
15	The signature serves no purpose other than authorizing the disclosure of PHI	

Policy #: HH.2021Δ
Title: **Exclusion Monitoring**
Department: Office of Compliance
Section: Regulatory Affairs & Compliance

CEO Approval: Michael Schrader _____

Effective Date: 05/01/12
Last Review Date: 12/~~01/16~~07/17
Last Revised Date: 12/~~01/16~~07/17

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy ~~establishes~~outlines a process for verifying and monitoring the eligibility of ~~an Employee~~Employees (permanent, temporary, volunteer and as-needed employees), ~~member~~members of the Governing Body, First Tier, Downstream, and Related Entities (FDRs), and vendors to participate in ~~CalOptima's federally funded~~CalOptima federal and/or state health care programs through state and federal exclusions and ineligible person/entity lists.

II. POLICY

A. CalOptima shall ensure all Employees, members of the Governing Body, FDRs, and vendors are eligible to participate in ~~CalOptima's federally funded~~CalOptima federal and/or state health care programs, and shall be responsible for:

1. Requiring an Employee, member of the Governing Body, FDR, or vendor to disclose and report pending suspensions, exclusions or debarments, of the Employee, member of the Governing Body, FDR, or ~~FDR~~vendor;

2. Conducting the initial eligibility verification of an Employee, member of the Governing Body, FDR, and vendor prior to hiring, renewing, or entering in any new agreement with CalOptima, or issuing payment thereto;

3. Performing eligibility verification of an Employee, member of the Governing Body, FDR, and vendor monthly thereafter; and

4. Maintaining records of all initial and monthly verification.

B. CalOptima shall not employ individuals, or contract with individuals~~,~~ or entities~~,~~ that are determined to be suspended, debarred, or excluded from participation in federal or state health care programs.

C. CalOptima shall not reimburse, or make payment ~~to, an individual, or entity,~~for services provided under the medical direction or on the prescription of an excluded person or entity, or make payment to, an individual or entity that is verified to be suspended, debarred, or excluded from participation in federal or state health care programs.

D. CalOptima will take immediate appropriate actions, with the assistance of its Legal Counsel, to terminate the employment of an individual, the contractual relationship with an FDR or vendor, or

the appointment of a member of the Governing Body, if such individual~~,~~ or entity~~,~~ is verified to be suspended, debarred, or excluded from participation in federal or state health care programs.

E. CalOptima shall utilize state and federal exclusion and ineligible person/entity list sources referenced in this policy to verify the eligibility of an Employee, member of the Governing Body, FDR, or vendor and shall maintain a record of completion indicating, at minimum:

1. The date of verification;

2. The exclusion and ineligible person/entity list source(s);

3. Verification results; and

4. The name of the person who conducted the verification.

F. CalOptima is to refer to the chart below to determine the responsible departments that conduct initial and/or monthly exclusions checks thereafter.

Group	**Prior to contracting/hire, CalOptima will verify through …**	**Monthly thereafter, CalOptima will verify through …**
Employees	Human Resources	Human Resources
Members of the Governing Body (Board of Directors)	~~Compliance~~Human Resources	~~Compliance~~Human Resources
CalOptima Committees	~~Compliance~~Human Resources	~~Compliance~~Human Resources
Pharmacy Prescriber Pharmacy Network Provider	PBM PBM	PBM PBM
FDRs (excluding Providers and Health Networks)	~~Purchasing~~Vendor Management	Regulatory Affairs & Compliance
Providers, Practitioners, Health Delivery Organizations (HDOs)	Quality/Credentialing	Quality/Credentialing
Health Networks	Contracting	Regulatory Affairs & Compliance
Medical Group Practice	Contracting	Quality/Credentialing

G. All CalOptima FDRs and vendors shall verify the eligibility of all its Employees and/or Downstream Entities (as defined above) prior to hiring/contracting and monthly thereafter. The FDR and vendors shall maintain a record of completion indicating, at minimum:

1. Date of verification;

2. The exclusion and ineligible person/entity list source(s);

3. Verification results; and

4. The name of the person who conducted the verification.

H. In the event an Employee, FDR or vendor has been identified in an exclusion list, the FDR or vendor must ~~immediately terminate the Employee, FDR, or vendor, and~~ immediately notify

CalOptima of the identified ineligible person/entity. CalOptima will determine whether it is appropriate to immediately terminate the Employee, FDR, or vendor.

I. The Office of Compliance may Audit CalOptima departments responsible for exclusion activities, as necessary.

III. PROCEDURE

A. Monitoring Sources

1. As applicable, CalOptima shall use Monitoring sources to retrieve verification and eligibility data, including, but not limited to:

   a. The General Services Administration's (GSA) System for Award Management (SAM) website;

   b. Medicare Exclusion Database (MED);

   c. Medi-Cal's Suspended and Ineligible (S&I) list;

   d. OIG Exclusions Database (OIG LEIE Database); and

   e. Other Monitoring sources as identified in CalOptima Policy GG.~~1609~~1650Δ: Credentialing and Recredentialing of Practitioners.

B. Initial Verification

1. Prior to hiring an Employee, having an individual become a member of the Governing Body or a CalOptima committee, or contracting with an FDR or vendor, the responsible ~~Department~~department identified in the chart in Section II.F. of this policy shall verify that the individual~~,~~ or entity~~,~~ is not Excluded by reviewing the Monitoring sources listed in Section III.A.1~~.~~ of this policy.

C. Monitoring

1. On a monthly basis, prior to publishing the next verification list update, the responsible department shall monitor Employees, FDRs, vendors, and members of the ~~Board~~Governing Body and committees by reviewing the Monitoring sources listed in Section III.A.1~~.~~ of this policy.

2. The responsible department shall deem an Employee, member of the Governing Body or committee, FDR, or vendor excluded, or ineligible, if identified on one (1) or more Monitoring sources. If applicable, the Office of Compliance shall complete a CalOptima Provider Alert to notify all appropriate CalOptima departments of the excluded, or ineligible, individual, or entity.

D. Actions Based on Discovery of Exclusion

1. In accordance with Title 42, Code of Federal Regulations, Section 1001.1901(b)(1), CalOptima shall immediately suspend and halt payment for services for an ineligible, or excluded, Employee, member of the Governing Body or CalOptima committee, FDR, or vendor. The

payment prohibition applies regardless of whether or not the Excluded individual, or entity, submits claims for reimbursement to, or the method of reimbursement by, federal or state health care programs.

2. CalOptima will take immediate appropriate actions, with the assistance of Legal Counsel, to terminate the employment of an individual, the contractual relationship with a FDR, or vendor, or the appointment of a member of the Governing Body, if such person, or entity, is determined to be Excluded. In the event, that a specific FDR, or vendor, employee is identified as Excluded, the applicable contractual relationship will also be reviewed to determine whether it may continue with the removal of the Excluded employee.

3. If CalOptima identifies an Excluded individual, or entity, after they are hired or contracted, the matter should be referred to the Office of Compliance for further investigation. As appropriate, CalOptima will engage in the service of Legal Counsel to take further action as appropriate. If the report identifies the removal of a suspended, excluded, or terminated Provider from CalOptima's Medi-Cal provider network, then the Office of Compliance shall report the action to DHCS within ten (10) business days and confirm that the provider is no longer receiving payments in connection with the Medi-Cal program.

4. CalOptima may recoup monies paid to the Employee, member of the Governing Body, FDR, or vendor while Excluded. ~~-~~Exclusion findings will be referred to the Office of Compliance for further action in accordance with CalOptima policy. As appropriate, CalOptima will engage in the service of Legal Counsel to take further action, as appropriate.

E. FDRs and Vendors

1. If CalOptima ~~declines to include~~denies an FDR~~,~~ or vendor~~, from participating~~ participation in ~~any~~ CalOptima program(s) on the basis of an Exclusion, it shall notify the FDR~~,~~ or vendor, in writing, noting the reason for denial~~.~~.. The FDR~~,~~ or vendor~~,~~ may contest the denial if they feel there is an error or inappropriate exclusion.~~-~~ If CalOptima determines that there is an inappropriate exclusion, correction shall be made, as stated in the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity Center for Medicare Letter issued June 29, 2011.

2. If the FDR, or vendor, has been re-instated by an excluding source listed on this policy, and is now in good standing and able to participate in ~~CalOptima's federally funded~~CalOptima federal and/or state health care programs, the FDR, or vendor, may express interest in participating with CalOptima. CalOptima will require evidence to verify re-instated participation in CalOptima's federally-funded health care programs. In addition, the FDR, or vendor, will require re-processing through contracting and/or Credentialing.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~D.~~A. ~~CalOptima PACE Program Agreement~~
~~E. CalOptima Policy GG.1609Δ: Credentialing and Recredentialing~~
~~F.~~D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~G. Department Health Care Services (DHCS) contract with CalOptima~~
E. CalOptima PACE Program Agreement
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
~~H.~~G. Medicaid Program Integrity Manual, Revised 2011
~~I.~~H. Medicare Managed Care Manual, ~~Chapters 9 and~~ Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Medicare Program Integrity Manual, Chapter 4. Revised ~~2014~~June 9, 2017
K. Sections 1128 and 156 of the Social Security Act
L. Title 42, Code of Federal Regulations (~~C.F.R.~~CFR.), §1001.1901
M. Title 42, United States Code (~~U.S.~~US.C.~~),~~), §1320a-7(a)(1)(D), (a)(4)(c), 1320a-7(b)(8)
~~N. Updated: OIG's Provider Self-Disclosure Protocol, Issued April 17, 2013~~
~~O.~~N. Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, Issued May 8, 2013

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/01/16~~: :~~ Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2012	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal
Revised	08/01/2013	HH.2021Δ	Vendor Exclusion Monitoring and Audits	Medi-Cal OneCare
Effective	05/01/2014	MA.9121	Exclusion Monitoring	OneCare
Revised	09/01/2015	HH.2021	~~Vendor~~ Exclusion Monitoring ~~and Audits~~	Medi-Cal
Revised	09/01/2015	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.~~2021~~2021Δ	~~Vendor~~ Exclusion Monitoring ~~and Audits~~	Medi-Cal OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/07/2017	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Excluded	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Policy #:	HH.2021Δ
Title:	**Exclusion Monitoring**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/12
Last Review Date:	12/07/17
Last Revised Date:	12/07/17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy outlines a process for verifying and monitoring the eligibility of Employees (permanent, temporary, volunteer and as-needed employees), members of the Governing Body, First Tier, Downstream, and Related Entities (FDRs), and vendors to participate in CalOptima federal and/or state health care programs through state and federal exclusions and ineligible person/entity lists.

II. POLICY

A. CalOptima shall ensure all Employees, members of the Governing Body, FDRs, and vendors are eligible to participate in CalOptima federal and/or state health care programs, and shall be responsible for:

1. Requiring an Employee, member of the Governing Body, FDR, or vendor to disclose and report pending suspensions, exclusions or debarments, of the Employee, member of the Governing Body, FDR, or vendor;

2. Conducting the initial eligibility verification of an Employee, member of the Governing Body, FDR, and vendor prior to hiring, renewing, or entering in any new agreement with CalOptima, or issuing payment thereto;

3. Performing eligibility verification of an Employee, member of the Governing Body, FDR, and vendor monthly thereafter; and

4. Maintaining records of all initial and monthly verification.

B. CalOptima shall not employ individuals, or contract with individuals or entities that are determined to be suspended, debarred, or excluded from participation in federal or state health care programs.

C. CalOptima shall not reimburse, or make payment for services provided under the medical direction or on the prescription of an excluded person or entity, or make payment to, an individual or entity that is verified to be suspended, debarred, or excluded from participation in federal or state health care programs.

D. CalOptima will take immediate appropriate actions, with the assistance of its Legal Counsel, to terminate the employment of an individual, the contractual relationship with an FDR or vendor, or

the appointment of a member of the Governing Body, if such individual or entity is verified to be suspended, debarred, or excluded from participation in federal or state health care programs.

E. CalOptima shall utilize state and federal exclusion and ineligible person/entity list sources referenced in this policy to verify the eligibility of an Employee, member of the Governing Body, FDR, or vendor and shall maintain a record of completion indicating, at minimum:

1. The date of verification;

2. The exclusion and ineligible person/entity list source(s);

3. Verification results; and

4. The name of the person who conducted the verification.

F. CalOptima is to refer to the chart below to determine the responsible departments that conduct initial and/or monthly exclusions checks thereafter.

Group	**Prior to contracting/hire, CalOptima will verify through …**	**Monthly thereafter, CalOptima will verify through …**
Employees	Human Resources	Human Resources
Members of the Governing Body (Board of Directors)	Human Resources	Human Resources
CalOptima Committees	Human Resources	Human Resources
Pharmacy Prescriber Pharmacy Network Provider	PBM PBM	PBM PBM
FDRs (excluding Providers and Health Networks)	Vendor Management	Regulatory Affairs & Compliance
Providers, Practitioners, Health Delivery Organizations (HDOs)	Quality/Credentialing	Quality/Credentialing
Health Networks	Contracting	Regulatory Affairs & Compliance
Medical Group Practice	Contracting	Quality/Credentialing

G. All CalOptima FDRs and vendors shall verify the eligibility of all its Employees and/or Downstream Entities (as defined above) prior to hiring/contracting and monthly thereafter. The FDR and vendors shall maintain a record of completion indicating, at minimum:

1. Date of verification;

2. The exclusion and ineligible person/entity list source(s);

3. Verification results; and

4. The name of the person who conducted the verification.

H. In the event an Employee, FDR or vendor has been identified in an exclusion list, the FDR or vendor must immediately notify CalOptima of the identified ineligible person/entity. CalOptima will determine whether it is appropriate to immediately terminate the Employee, FDR, or vendor.

I. The Office of Compliance may Audit CalOptima departments responsible for exclusion activities, as necessary.

III. PROCEDURE

A. Monitoring Sources

1. As applicable, CalOptima shall use Monitoring sources to retrieve verification and eligibility data, including, but not limited to:

   a. The General Services Administration's (GSA) System for Award Management (SAM) website;

   b. Medicare Exclusion Database (MED);

   c. Medi-Cal's Suspended and Ineligible (S&I) list;

   d. OIG Exclusions Database (OIG LEIE Database); and

   e. Other Monitoring sources as identified in CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners.

B. Initial Verification

1. Prior to hiring an Employee, having an individual become a member of the Governing Body or a CalOptima committee, or contracting with an FDR or vendor, the responsible department identified in the chart in Section II.F. of this policy shall verify that the individual or entity is not Excluded by reviewing the Monitoring sources listed in Section III.A.1 of this policy.

C. Monitoring

1. On a monthly basis, prior to publishing the next verification list update, the responsible department shall monitor Employees, FDRs, vendors, and members of the Governing Body and committees by reviewing the Monitoring sources listed in Section III.A.1 of this policy.

2. The responsible department shall deem an Employee, member of the Governing Body or committee, FDR, or vendor excluded, or ineligible, if identified on one (1) or more Monitoring sources. If applicable, the Office of Compliance shall complete a CalOptima Provider Alert to notify all appropriate CalOptima departments of the excluded, or ineligible, individual, or entity.

D. Actions Based on Discovery of Exclusion

1. In accordance with Title 42, Code of Federal Regulations, Section 1001.1901(b)(1), CalOptima shall immediately suspend and halt payment for services for an ineligible, or excluded, Employee, member of the Governing Body or CalOptima committee, FDR, or vendor. The payment prohibition applies regardless of whether or not the Excluded individual, or entity, submits claims for reimbursement to, or the method of reimbursement by, federal or state health care programs.

2. CalOptima will take immediate appropriate actions, with the assistance of Legal Counsel, to terminate the employment of an individual, the contractual relationship with a FDR, or vendor, or the appointment of a member of the Governing Body, if such person, or entity, is determined to be Excluded. In the event, that a specific FDR, or vendor, employee is identified as Excluded, the applicable contractual relationship will also be reviewed to determine whether it may continue with the removal of the Excluded employee.

3. If CalOptima identifies an Excluded individual, or entity, after they are hired or contracted, the matter should be referred to the Office of Compliance for further investigation. As appropriate, CalOptima will engage in the service of Legal Counsel to take further action as appropriate. If the report identifies the removal of a suspended, excluded, or terminated Provider from CalOptima's Medi-Cal provider network, then the Office of Compliance shall report the action to DHCS within ten (10) business days and confirm that the provider is no longer receiving payments in connection with the Medi-Cal program.

4. CalOptima may recoup monies paid to the Employee, member of the Governing Body, FDR, or vendor while Excluded. Exclusion findings will be referred to the Office of Compliance for further action in accordance with CalOptima policy. As appropriate, CalOptima will engage in the service of Legal Counsel to take further action, as appropriate.

E. FDRs and Vendors

1. If CalOptima denies an FDR or vendor participation in CalOptima program(s) on the basis of an Exclusion, it shall notify the FDR or vendor, in writing, noting the reason for denial. The FDR or vendor may contest the denial if they feel there is an error or inappropriate exclusion. If CalOptima determines that there is an inappropriate exclusion, correction shall be made, as stated in the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity Center for Medicare Letter issued June 29, 2011.

2. If the FDR, or vendor, has been re-instated by an excluding source listed on this policy, and is now in good standing and able to participate in CalOptima federal and/or state health care programs, the FDR, or vendor, may express interest in participating with CalOptima. CalOptima will require evidence to verify re-instated participation in CalOptima's federally-funded health care programs. In addition, the FDR, or vendor, will require re-processing through contracting and/or Credentialing.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima PACE Program Agreement
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
G. Medicaid Program Integrity Manual, Revised 2011

H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Medicare Program Integrity Manual, Chapter 4. Revised June 9, 2017
K. Sections 1128 and 156 of the Social Security Act
L. Title 42, Code of Federal Regulations (CFR.), §1001.1901
M. Title 42, United States Code (U.S.C), §1320a-7(a)(1)(D), (a)(4)(c), 1320a-7(b)(8)
N. Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, Issued May 8, 2013

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
B. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2012	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal
Revised	08/01/2013	HH.2021Δ	Vendor Exclusion Monitoring and Audits	Medi-Cal OneCare
Effective	05/01/2014	MA.9121	Exclusion Monitoring	OneCare
Revised	09/01/2015	HH.2021	Exclusion Monitoring	Medi-Cal
Revised	09/01/2015	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Excluded	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Policy #:	HH.2022Δ
Title:	**Record Retention and Access**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance

CEO Approval: Michael Schrader _____

Effective Date:	06/01/13
Last Review Date:	12/~~01/16~~07/17
Last Revised Date:	12/~~01/16~~07/17

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy establishes the requirements for CalOptima and its First Tier, Downstream and Related Entities (FDRs) to retain and make available premises, contracts, books, documents, records, ~~and~~ financial statements, equipment, computers, or other electronic systems, in accordance with federal and state regulations for the purpose of any audit, or investigation, of a CalOptima program.

II. POLICY

A. CalOptima and its FDRs shall retain and make available contracts, books, documents, records, and financial statements, in accordance with the provisions of this policy. These documents include, but are not limited to, the following:

1. Data relating to Medicare utilization and costs;
2. Reinsurance costs;
3. Low-income subsidy payments;
4. Risk corridor costs;
5. Bid calculations;
6. Rebate information;
7. Medical Records;
8. Medical charts and prescription files; ~~and~~
9. Records related to/supporting Health Network Medical Loss Ratio (MLR) calculations;
10. Hierarchical Condition Categories (HCC) and risk adjustment records;
11. Encounter data;

12. Member Grievance and Appeal records;

13. Base data as defined in Title 42 Code of Federal Regulations (C.F.R.) section 438.5(c);

14. Data, information, and documentation specified in 42 C.F.R. sections 438.604, 606, 608, and 610; and

~~9.~~15. Other documentation pertaining to medical and non-medical services rendered to Members.

~~B.~~ CalOptima and its FDRs shall maintain and make available ~~contracts, books, documents, records, and financial statements regarding the Medi-Cal program for a minimum of five (5) years from the end of the current fiscal year, in which, the date of service occurred, or, in the event of notification of an audit, or investigation, until such time as the matter under audit, or investigation, has been resolved, whichever is later.~~

~~1. For Medi-Cal, if there is a termination, dispute, or allegation of fraud, or similar fault, document retention requirements for CalOptima and its FDRs may be extended to at least six (6) years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud, or similar fault.~~

~~2. In the event an FDR's contract provides for a longer retention and access time period, that time period shall apply.~~

~~C.~~B. ~~CalOptima's and its FDRs shall maintain and make available contracts, books, documents, records, and financial statements regarding the CalOptima Medicare programs for a minimum of ten (10) years, and such records shall be maintained for an additional~~all records and documents for a minimum of ten (10) years from the final date of the contract period, or from completion of any audit or investigation, whichever is later.

1. ~~For Medicare, if~~If there is a termination, dispute, or allegation of fraud, or similar fault, document retention requirements for CalOptima and its FDRs may be extended to ten (10) years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud, or similar fault.

~~D.~~C. CalOptima ~~and its FDRs~~ shall retain and make available all of its premises, facilities, equipment, contracts, books, documents, records, encounter data (for a period of at least ten (10) years), and other electronic systems pertaining to the goods and ~~financial statements~~services provided to Members, available to any authorized state and federal agencies or contractors for inspections, evaluations, examinations or copying, and auditing including, but are not limited to:

1. Centers for Medicare & Medicaid Services (CMS);

2. Department of Managed Health Care (DMHC);

3. Department of Health Care Services (DHCS);

4. The U.S. Department of Health and Human Services (HHS Office of Inspector General (OIG);

5. The Comptroller General;

6. Department of Justice;

~~5.~~7. The U.S. Government Accountability Office (GAO); and

~~6.~~8. Any Quality Improvement Organization (QIO) or accrediting organizations, including NCQA, their designees and other representatives of regulatory or accrediting organizations.

D. An FDR shall retain and make available all of its premises, facilities, equipment, contracts, books, documents, records, encounter data (for a period of at least ten (10) years), and other electronic systems pertaining to the goods and services provided to Members, available to CalOptima and any authorized state and federal agencies or contractors, as described in Section II.C. 1-8 of this Policy, for inspections, evaluations, examinations or copying, and auditing.

1. If DHCS, CMS, or the HHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS of the HHS Inspector General may inspect, evaluate, and audit an FDR at any time.

2. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the FDR from participation in the Medi-Cal program; seek recovery of payments made to the FDR; impose other sanctions provided under the State Plan, and direct CalOptima to terminate its agreement with the FDR due to fraud.

III. PROCEDURE

A. CalOptima and its FDRs shall provide an authorized entity with the requested and required access to premises, contracts, books, documents, records, ~~and~~ financial statements, equipment, computers, or other electronic systems at any time during normal business hours for audit and other investigative activities.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
~~E. CalOptima Policy AA.1000: Glossary of Terms~~
~~F.~~E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
F. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
G. Medicare Managed Care Manual, Chapter 21
H. Medicare Prescription Drug Benefit Manual, Chapter 9
~~G.~~I. Title 42, Code of Federal Regulations (C.F.R.), §422.504(d)(2~~)~~), §438.230(c), §438.3(h), §438.604, §606, §608, §438.3(u); and §610

VI. REGULATORY AGENCY APPROVALS

A. 07/12/13: Department of Health Care Services

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2007	MA.9106	Record Retention and Access	OneCare
Revised	06/01/2013	MA.9106	Record Retention and Access	OneCare
Effective	06/01/2013	HH.2022Δ	Record Retention and Access	Medi-Cal OneCare
Revised	09/01/2014	MA.9106	Record Retention and Access	OneCare
Revised	09/01/2015	HH.2022	Record Retention and Access	Medi-Cal
Revised	09/01/2015	MA.9106	Record Retention and Access	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2022Δ	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9106	Record Retention and Access	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2022Δ	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service. OneCare: Any of the procedures that deal with the review of an adverse organization determination on the health care services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service. These procedures include reconsideration by CalOptima and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.

Term	Definition
Grievance	Medi-Cal: An oral or written expression of dissatisfaction with any aspect of the CalOptima program, other than an Adverse Benefit Determination. OneCare and OneCare Connect: Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action.
Hierarchical Coding Categories (HCC)	A risk-adjusted model developed by CMS to adjust Medicare payments to health care plans for the health expenditure risk of Members.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Members by the total revenue received from CalOptima. Health Network medical costs would include payments to physicians (i.e. capitation, fee-for-service, or salary), medical groups/Independent Practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A beneficiary who is enrolled in a CalOptima Program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Policy #:	HH.2022Δ
Title:	**Record Retention and Access**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/13
Last Review Date:	12/07/17
Last Revised Date:	12/07/17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes the requirements for CalOptima and its First Tier, Downstream and Related Entities (FDRs) to retain and make available premises, contracts, books, documents, records, financial statements, equipment, computers, or other electronic systems, in accordance with federal and state regulations for the purpose of any audit, or investigation, of a CalOptima program.

II. POLICY

A. CalOptima and its FDRs shall retain and make available contracts, books, documents, records, and financial statements, in accordance with the provisions of this policy. These documents include, but are not limited to, the following:

1. Data relating to Medicare utilization and costs;
2. Reinsurance costs;
3. Low-income subsidy payments;
4. Risk corridor costs;
5. Bid calculations;
6. Rebate information;
7. Medical Records;
8. Medical charts and prescription files;
9. Records related to/supporting Health Network Medical Loss Ratio (MLR) calculations;
10. Hierarchical Condition Categories (HCC) and risk adjustment records;
11. Encounter data;
12. Member Grievance and Appeal records;

13. Base data as defined in Title 42 Code of Federal Regulations (C.F.R.) section 438.5(c);

14. Data, information, and documentation specified in 42 C.F.R. sections 438.604, 606, 608, and 610; and

15. Other documentation pertaining to medical and non-medical services rendered to Members.

B. CalOptima and its FDRs shall maintain and make available all records and documents for a minimum of ten (10) years from the final date of the contract period, or from completion of any audit or investigation, whichever is later.

1. If there is a termination, dispute, or allegation of fraud, or similar fault, document retention requirements for CalOptima and its FDRs may be extended to ten (10) years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud, or similar fault.

C. CalOptima shall retain and make available all of its premises, facilities, equipment, contracts, books, documents, records, encounter data (for a period of at least ten (10) years), and other electronic systems pertaining to the goods and services provided to Members, available to any authorized state and federal agencies or contractors for inspections, evaluations, examinations or copying, and auditing including, but are not limited to:

1. Centers for Medicare & Medicaid Services (CMS);

2. Department of Managed Health Care (DMHC);

3. Department of Health Care Services (DHCS);

4. The U.S. Department of Health and Human Services (HHS Office of Inspector General (OIG);

5. The Comptroller General;

6. Department of Justice;

7. The U.S. Government Accountability Office (GAO); and

8. Any Quality Improvement Organization (QIO) or accrediting organizations, including NCQA, their designees and other representatives of regulatory or accrediting organizations.

D. An FDR shall retain and make available all of its premises, facilities, equipment, contracts, books, documents, records, encounter data (for a period of at least ten (10) years), and other electronic systems pertaining to the goods and services provided to Members, available to CalOptima and any authorized state and federal agencies or contractors, as described in Section II.C. 1-8 of this Policy, for inspections, evaluations, examinations or copying, and auditing.

1. If DHCS, CMS, or the HHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS of the HHS Inspector General may inspect, evaluate, and audit an FDR at any time.

2. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the FDR from participation in the Medi-Cal program; seek recovery of payments made to the FDR; impose other sanctions provided under the State Plan, and direct CalOptima to terminate its agreement with the FDR due to fraud.

III. PROCEDURE

A. CalOptima and its FDRs shall provide an authorized entity with the requested and required access to premises, contracts, books, documents, records, financial statements, equipment, computers, or other electronic systems at any time during normal business hours for audit and other investigative activities.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
F. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
G. Medicare Managed Care Manual, Chapter 21
H. Medicare Prescription Drug Benefit Manual, Chapter 9
I. Title 42, Code of Federal Regulations (C.F.R.), §422.504(d)(2), §438.230(c), §438.3(h), §438.604, §606, §608, §438.3(u); and §610

VI. REGULATORY AGENCY APPROVALS

A. 07/12/13: Department of Health Care Services

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
B. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2007	MA.9106	Record Retention and Access	OneCare
Revised	06/01/2013	MA.9106	Record Retention and Access	OneCare
Effective	06/01/2013	HH.2022Δ	Record Retention and Access	Medi-Cal OneCare
Revised	09/01/2014	MA.9106	Record Retention and Access	OneCare
Revised	09/01/2015	HH.2022	Record Retention and Access	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	MA.9106	Record Retention and Access	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2022Δ	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9106	Record Retention and Access	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2022Δ	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service. OneCare: Any of the procedures that deal with the review of an adverse organization determination on the health care services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service. These procedures include reconsideration by CalOptima and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
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Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.

Term	Definition
Grievance	Medi-Cal: An oral or written expression of dissatisfaction with any aspect of the CalOptima program, other than an Adverse Benefit Determination. OneCare and OneCare Connect: Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action.
Hierarchical Coding Categories (HCC)	A risk-adjusted model developed by CMS to adjust Medicare payments to health care plans for the health expenditure risk of Members.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Members by the total revenue received from CalOptima. Health Network medical costs would include payments to physicians (i.e. capitation, fee-for-service, or salary), medical groups/Independent Practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A beneficiary who is enrolled in a CalOptima Program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

1

Policy #:	HH.2028Δ
Title:	**Code of Conduct**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	09/01/15
Last Review Date:	12/~~01/16~~ 07/17
Last Revision Date:	12/~~01/16~~ 07/17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy describes the process CalOptima utilizes to review, approve, and communicate its expectation that all Employees, members of its Governing Body, and First Tier, Downstream, and Related Entities (FDRs) conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

II. POLICY

A. CalOptima requires that all members of the Governing Body, Employees, and FDRs to conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

B. Failure to comply with the Code of Conduct~~,~~ or the guidelines for behavior that the Code of Conduct represents~~,~~ may lead to disciplinary action, up to and including termination.~~-~~ Employees and FDRs are expected to inform CalOptima's Office of Compliance immediately in the event of any violations to the Code of Conduct, in accordance with CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies.

C. Employees, members of the Governing Body, and FDRs shall provide attestations they have received, read, understood and will comply with the Code of Conduct upon appointment, hire, or the commencement of the contract and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services.

III. PROCEDURE

A. Reviewing and Approving the Code of Conduct

1. The Office of Compliance is responsible for ensuring a review of the current Code of Conduct, at least annually, or more frequently as needed. The following sources should be considered to determine if changes to the Code of Conduct are required:

a. Changes in state and federal laws, or regulations;

b. Changes in health care program requirements; and

c. Other guidance, as applicable.

2. Once approved by the Board of Directors, the Office of Compliance is responsible for ensuring the Code of Conduct is made available ~~by uploading~~ on ~~the~~ CalOptima's InfoNet, and vendor~~,~~ and provider websites.

B. Distributing and Monitoring for CalOptima Employees

1. All CalOptima Employees shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified.

2. If mid-year, or annual, revisions are made to the Code of Conduct, the Office of Compliance will inform the Human Resources Department, who will communicate to all Employees that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute via web-based training, in accordance with CalOptima Policy HH.2023Δ: Compliance Training.

b. If there are revisions ~~to the~~ to the Code of Conduct that occur mid-year, the Human Resources Department shall compose and distribute an email to all Employees announcing an updated Code of Conduct is available on CalOptima's InfoNet and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

3. The Code of Conduct shall be communicated to all Employees through CalOptima's web-based learning management system~~,~~ or other means of distribution, in accordance with CalOptima Policy HH.2023Δ: Compliance Training.

C. Distributing and Monitoring for Members of the Governing Body

1. All members of CalOptima's Governing Body shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, ~~and~~ at least annually thereafter, ~~as well as~~and when the Code of Conduct is modified.

2. If mid-year or annual revisions are made to the Code of Conduct, the Office of Compliance will inform the Clerk of the Board, who will communicate to all members of the Governing Body that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute the Code of Conduct via web-based training, in accordance with CalOptima Policy HH.2023Δ: Compliance Training. The Clerk of the Board shall also provide a copy of the current Code of Conduct to all members of the Governing Body through a written memorandum and request an updated attestation to be executed from all members of the Governing Body.

b. If there are revisions ~~to the~~ to the Code of Conduct that occur mid-year, the Clerk of the Board shall compose and distribute a written memorandum to all members of the Governing Body announcing an updated Code of Conduct is available and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

D. Distributing and Monitoring for FDRs

1. The Office of Compliance shall ensure the updated Code of Conduct is uploaded on to ~~the~~ CalOptima vendor and provider websites.

2. Upon contracting, the Office of Compliance distributes an FDR compliance attestation package composed of ~~compliance documents, including CalOptima's Code of Conduct and an FDR attestation, that confirms receipt of the CalOptima Code of Conduct~~a cover letter containing a link to direct FDRs to CalOptima's policies and procedures, and code of conduct, as well as instructions on how to access CMS training modules on the topics for Fraud Waste and Abuse, General Compliance and HIPAA. The packet also contains an FDR and Offshore attestation that are due within sixty (60) calendar days.

3. All CalOptima FDRs shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified. Additionally, the Code of Conduct is provided through the CalOptima vendor and provider websites with notification of updates provided via email.

   a. Upon contracting and annually thereafter, FDRs shall confirm receipt and understanding of CalOptima's Code of Conduct via the initial and annual FDR attestation.

4. FDRs are required to disseminate copies of the CalOptima's Code of Conduct and policies and procedures~~,~~ to their employees, agents, and~~/or~~ Downstream Entities.

5. Annually, the Office of Compliance shall request an updated attestation to be executed from all FDRs.~~-~~ Failure to submit the requested documents may result in issuance of a notice of non-compliance, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

6. The Office of Compliance shall communicate to all FDRs any update(s) to compliance documents with instructions to access the CalOptima vendor and provider websites.

IV. ATTACHMENTS

A. FDR Compliance Attestation

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2005Δ: Corrective Action Plan
F. CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies
G. CalOptima Policy HH.2023Δ: Compliance Training

H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. Medicare Managed Care Manual, ~~Chapters 9 and~~Chapter 21
J. Medicare Prescription Drug Benefit Manual, Chapter 9
~~J.~~K. Title 42, Code of Federal Regulations (C.F.R.), §455.2
~~K.~~L. Title 42, Code of Federal Regulations (C.F.R.), §422.503(b)(4)(vi)(A)
~~L.~~M. Title 42, Code of Federal Regulations (C.F.R.), §423.504(b)(4)(vi)(A)
~~M.~~N. Title 42, Code of Federal Regulations (C.F.R.), §438.608
~~N.~~O. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/01/16: ~~–~~ Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9120	Code of Conduct	OneCare
Revised	11/01/2014	MA.9120	Code of Conduct	OneCare
Effective	09/01/2015	HH.2028	Code of Conduct	Medi-Cal
Revised	09/01/2015	MA.9120	Code of Conduct	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9120	Code of Conduct	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR):	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Policy #:	HH.2028Δ
Title:	**Code of Conduct**
Department:	Office of Compliance
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Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the process CalOptima utilizes to review, approve, and communicate its expectation that all Employees, members of its Governing Body, and First Tier, Downstream, and Related Entities (FDRs) conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

II. POLICY

A. CalOptima requires that all members of the Governing Body, Employees, and FDRs to conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

B. Failure to comply with the Code of Conduct or the guidelines for behavior that the Code of Conduct represents may lead to disciplinary action, up to and including termination. Employees and FDRs are expected to inform CalOptima's Office of Compliance immediately in the event of any violations to the Code of Conduct, in accordance with CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies.

C. Employees, members of the Governing Body, and FDRs shall provide attestations they have received, read, understood and will comply with the Code of Conduct upon appointment, hire, or the commencement of the contract and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services.

III. PROCEDURE

A. Reviewing and Approving the Code of Conduct

1. The Office of Compliance is responsible for ensuring a review of the current Code of Conduct, at least annually, or more frequently as needed. The following sources should be considered to determine if changes to the Code of Conduct are required:

   a. Changes in state and federal laws, or regulations;

b. Changes in health care program requirements; and

c. Other guidance, as applicable.

2. Once approved by the Board of Directors, the Office of Compliance is responsible for ensuring the Code of Conduct is made available on CalOptima's InfoNet, and vendor and provider websites.

B. Distributing and Monitoring for CalOptima Employees

1. All CalOptima Employees shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified.

2. If mid-year, or annual, revisions are made to the Code of Conduct, the Office of Compliance will inform the Human Resources Department, who will communicate to all Employees that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute via web-based training, in accordance with CalOptima Policy HH.2023Δ: Compliance Training.

b. If there are revisions to the Code of Conduct that occur mid-year, the Human Resources Department shall compose and distribute an email to all Employees announcing an updated Code of Conduct is available on CalOptima's InfoNet and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

3. The Code of Conduct shall be communicated to all Employees through CalOptima's web-based learning management system or other means of distribution, in accordance with CalOptima Policy HH.2023Δ: Compliance Training.

C. Distributing and Monitoring for Members of the Governing Body

1. All members of CalOptima's Governing Body shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, at least annually thereafter, and when the Code of Conduct is modified.

2. If mid-year or annual revisions are made to the Code of Conduct, the Office of Compliance will inform the Clerk of the Board, who will communicate to all members of the Governing Body that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute the Code of Conduct via web-based training, in accordance with CalOptima Policy HH.2023Δ: Compliance Training. The Clerk of the Board shall also provide a copy of the current Code of Conduct to all members of the Governing Body through a written memorandum and request an updated attestation to be executed from all members of the Governing Body.

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announcing an updated Code of Conduct is available and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

D. Distributing and Monitoring for FDRs

1. The Office of Compliance shall ensure the updated Code of Conduct is uploaded on to CalOptima vendor and provider websites.

2. Upon contracting, the Office of Compliance distributes an FDR compliance attestation package composed of a cover letter containing a link to direct FDRs to CalOptima's policies and procedures, and code of conduct, as well as instructions on how to access CMS training modules on the topics for Fraud Waste and Abuse, General Compliance and HIPAA. The packet also contains an FDR and Offshore attestation that are due within sixty (60) calendar days.

3. All CalOptima FDRs shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified. Additionally, the Code of Conduct is provided through the CalOptima vendor and provider websites with notification of updates provided via email.

   a. Upon contracting and annually thereafter, FDRs shall confirm receipt and understanding of CalOptima's Code of Conduct via the initial and annual FDR attestation.

4. FDRs are required to disseminate copies of the CalOptima's Code of Conduct and policies and procedures to their employees, agents, and Downstream Entities.

5. Annually, the Office of Compliance shall request an updated attestation to be executed from all FDRs. Failure to submit the requested documents may result in issuance of a notice of non-compliance, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

6. The Office of Compliance shall communicate to all FDRs any update(s) to compliance documents with instructions to access the CalOptima vendor and provider websites.

IV. ATTACHMENTS

A. FDR Compliance Attestation

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2005Δ: Corrective Action Plan
F. CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies
G. CalOptima Policy HH.2023Δ: Compliance Training
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. Medicare Managed Care Manual, Chapter 21

J. Medicare Prescription Drug Benefit Manual, Chapter 9
K. Title 42, Code of Federal Regulations (C.F.R.), §455.2
L. Title 42, Code of Federal Regulations (C.F.R.), §422.503(b)(4)(vi)(A)
M. Title 42, Code of Federal Regulations (C.F.R.), §423.504(b)(4)(vi)(A)
N. Title 42, Code of Federal Regulations (C.F.R.), §438.608
O. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors
B. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9120	Code of Conduct	OneCare
Revised	11/01/2014	MA.9120	Code of Conduct	OneCare
Effective	09/01/2015	HH.2028	Code of Conduct	Medi-Cal
Revised	09/01/2015	MA.9120	Code of Conduct	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9120	Code of Conduct	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR):	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via ~~fax (714) 481-6457,~~ email Compliance@caloptima.org , or mail: Cal Optima, Office of Compliance, Attn: Annie Phillips 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for (existing FDRs) or sixty (60) calendar days for (new FDRs) of this notice.

Check which CalOptima program(s) this form pertains to:

- ☐ OneCare Connect
- ☐ OneCare HMO SNP
- ☐ Medi-Cal
- ☐ PACE

I hereby attest that [_____(the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. Provide effective Fraud, Waste and Abuse Training and compliance training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use (Select all that apply):

- ☐ CMS's Fraud, Waste, and Abuse ~~Training and compliance training module.~~ training, General Compliance training, and General HIPAA training modules. (The Organization shall maintain records per CMS retention requirement)
- ☐ An internal training program that meets CMS's Fraud, Waste, and Abuse ~~and compliance training module requirements.~~ training, General Compliance training, and General HIPAA training modules. Organizations with internal training programs are asked to submit a copy of their training materials to be reviewed by CalOptima's Office of Compliance to ensure they meet CMS' requirements. (The Organization shall maintain records per CMS retention requirement. ~~(The Organization shall maintain records per CMS retention requirement)~~

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers: (i) based on their job function within the first ninety (90) days of hire and at least annually thereafter as a condition of appointment, employment or contracting, (ii) when requirements change; (iii) when such persons work in an area previously found to be non-compliant with program requirements or implicated in past misconduct.

III. Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as

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applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization.

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IV. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the (Suspended and Ineligible Provider List) S & I Medi-Cal, (Health and Human Services) HHS, (Office of Inspector General) OIG List of Excluded Individuals & Entities list, (System for Award Management) SAM/(General Services Administration) GSA Debarment list (here after "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. Will report suspected fraud, waste, and abuse, as well as all other forms of non-compliance, as it relates to CalOptima.

VII. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII Are aware that persons reporting suspected fraud, waste, and abuse, and other non-compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. Retain documented evidence of compliance with the above, including training material and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request for auditing purposes.

Note: CalOptima's policies and procedures, CMS training module instructions for Fraud, Waste, and Abuse, General Compliance, General HIPAA, as well as CalOptima's Code of Conduct can be accessed at CalOptima's vendor page:
https://www.caloptima.org/en/Vendors.aspx.
Vendors Home -- > FDR Compliance --> Scroll down to Training

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

Signature	Date
Name	Organization

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Email

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- ☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training modules. (The Organization shall maintain records per CMS retention requirement)
- ☐ An internal training program that meets CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training modules. Organizations with internal training programs are asked to submit a copy of their training materials to be reviewed by CalOptima's Office of Compliance to ensure they meet CMS' requirements. (The Organization shall maintain records per CMS retention requirement.

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III. Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization.

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Vendors Home -- > FDR Compliance --> Scroll down to Training

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

_____	_____
Signature	Date
_____	_____
Name	Organization
_____	
Email	

Policy #:	MA.7008
Title:	**Delegation and Oversight of Credentialing and Recredentialing Activities**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	Michael Schrader
Effective Date:	12/95
Last Review Date:	9/1/15
Last Revision Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect

I. PURPOSE

To establish the process by which CalOptima shall provide and document evidence of oversight of delegated Credentialing and Recredentialing activities.

II. DEFINITIONS

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), or designated representatives. Delegates may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.
Recredentialing	The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in OneCare and OneCare Connect.

III. POLICY

A. CalOptima may delegate Credentialing and Recredentialing of a Practitioner to a Health Network or other delegated Provider, in accordance with this policy.

B. CalOptima shall comply with California rules of Delegation of Quality Improvement Activities, in accordance with Title 28 California Code of Regulations, Section 1300.70(b)(1).

C. CalOptima shall comply with Title 42 Code of Federal Regulations, Section 438.230(b), the Medicaid managed care regulation governing delegation and oversight.

D. CalOptima shall remain accountable for Credentialing and Recredentialing of its Practitioners, even if CalOptima delegates all or part of these activities.

E. CalOptima shall be responsible to perform a Pre-Delegation Readiness Assessment before implementing Delegation. The following shall be mutually agreed upon between CalOptima and the delegated party:

1. A written Delegation Acknowledgment and Acceptance Agreement Document (Delegation Agreement) describing all of the delegated Credentialing activities; and

2. CalOptima shall retain the right to approve, suspend, and terminate individual Practitioners, Providers, and sites in situations where CalOptima has delegated decision making, as addressed in the Delegation Agreement.

F. On an annual basis, CalOptima shall perform Credentialing written policy and procedure, and file review audit against contractual standards for each year that delegation, is in effect. The annual audit shall be based on the responsibilities stated in the Delegation Agreement and performance of delegated activities, as well as the appropriate application of contractual standards.

G. On a monthly basis, CalOptima shall evaluate required reports as agreed upon in the Delegation Agreement, unless specified otherwise. CalOptima will also conduct a monthly Credentialing and Re-credentialing file review for each line of business.

H. CalOptima shall identify and follow-up on opportunities for improvement, if applicable.

I. CalOptima shall require a delegated Health Network or other delegated Provider to respond to a Corrective Action Plan (CAP), based on any deficiency or area of non-compliance determined during the Pre-Delegation Readiness Assessment, Monthly File Review, or Annual Audit.

IV. PROCEDURE

A. The written Delegation Agreement shall include the following:

1. Mutual agreement demonstrated by signatures from both CalOptima and the delegated Health Network or other delegated Provider, and a description of:

a. Delegated activities;

b. CalOptima and the delegated Health Network, or other delegated Provider responsibilities, which at a minimum include:

i. Acceptance of applications, reapplications, and attestations;

ii. Collection of all data elements, in accordance with CalOptima Policy GG.1609Δ: Credentialing and Recredentialing;

iii. Collection and evaluation of ongoing monitoring information; and

iv. Decision-making in respect to oversight of Credentialing activities.

c. Reporting responsibilities, which shall indicate a minimum of monthly reporting, unless specified otherwise. The reporting responsibilities shall be noted on the Monthly Credentialing Universe, and include:

i. A list of Credentialed and Recredentialed Practitioners, submitted monthly to CalOptima;

d. The process by which CalOptima evaluates the delegated Health Network or other delegated Provider performance, which includes:

i. Pre-Delegation Readiness Assessment;

ii. Monthly File Review;

iii. Annual Audit; and

iv. Reporting.

e. Remedies available to CalOptima if the delegated Health Network or other delegated Provider does not fulfill its obligations, including revocation of the Delegation agreement, and Sanctions as referenced, in CalOptima Policy MA.9105: Sanctions;

f. CalOptima's right to approve, suspend and terminate individual Practitioners, Providers, and sites in situations where CalOptima has delegated decision making; and

g. CalOptima's right to reject a Practitioner upon reason that the Practitioner has failed to meet the Credentialing or Recredentialing requirements, as outlined in the Delegation Agreement and CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

B. Pre-Delegation Readiness Assessment

1. CalOptima shall conduct a pre-delegation readiness assessment of a Health Network or other delegated Provider to determine the Health Network's or other delegated Provider's ability to implement delegated Credentialing and Recredentialing activities prior to the agreement and implementation of a Delegation Agreement.

2. The pre-delegation readiness assessment shall consist of a comprehensive desk review and on-site audit, utilizing the Delegation Oversight Audit Tool, which will evaluate a Health Network's or other delegated Provider's capacity to provide all delegated functions. The evaluation shall include:

   a. Written review of the Health Network's or other delegated Provider's understanding of applicable standards;

   b. Delegated tasks;

   c. Review of policy and procedures;

   d. Staffing capabilities;

   e. Performance records;

   f. Review of Credentialing system; and

   g. Credentialing and Recredentialing file review.

3. Upon completion of the pre-delegation readiness assessment, CalOptima's Audit & Oversight Director shall report the pre-delegation readiness assessment results to the Delegation Oversight Committee (DOC) Meeting.

4. The DOC shall determine if the Health Network or other delegated provider meets CalOptima's criteria for Delegation of Credentialing and Recredentialing activities based on the results of the Health Network's or other delegated Provider's pre-delegation readiness assessment.

   a. If the DOC determines that a Health Network or other delegated Provider does not meet CalOptima's criteria for Delegation of Credentialing and Recredentialing activities, CalOptima may reassess such Health Network or other delegated Provider no earlier than three (3) months after the initial pre-delegation readiness assessment.

C. Health Network or other delegated Provider Responsibilities

1. A delegated Health Network or other delegated Provider shall:

   a. Develop and implement processes, in accordance with this policy for the Credentialing and Recredentialing of Practitioners with whom it contracts or employs;

   b. Develop policies and procedures that:

i. Are consistent with this policy, and specify:

a) Types of Practitioners covered;

b) Criteria for Credentialing and Recredentialing; and

c) Verification sources used; and

ii. Address the following:

a) The process to sub-delegate Credentialing or Recredentialing activities;

b) The process used to ensure that Credentialing and Recredentialing are conducted in a non-discriminatory manner;

c) The process for written notification to a Practitioner of any information obtained during the Health Network's or other delegated Provider's Credentialing process that varies substantially from the information provided to the Health Network or other delegated provider by the Practitioner;

d) The process to ensure that Practitioners are notified of the Credentialing or Recredentialing decision within sixty (60) calendar days after the Peer Review Body's (PRB) decision;

e) The medical director or other designated physician's direct responsibility and participation in the Credentialing program;

f) The process used to ensure the Confidentiality of all information obtained in the Credentialing process, except as otherwise provided by law; and

g) The process for making Credentialing and Recredentialing decisions; and

iii. Include the Practitioner's right to:

a) Review information submitted to support his or her Credentialing application;

b) Correct erroneous information;

c) Request information on the status of his or her Credentialing or Recredentialing application; and

d) Receive notification of these rights; and

iv. Address ongoing monitoring of:

a) Medicare and Medicaid Sanctions;

b) State Sanctions or limitations on licensure; and

c) Complaints.

c. Develop policies and procedures to verify the participation status of the Health Network's or other delegated Provider's agents to ensure that they shall:

i. Immediately disclose to CalOptima's Audit & Oversight Department any pending investigation involving, or any determination of, suspension, exclusion, or debarment by the Health Network or other delegated Provider, or Health Network or other delegated Provider agents, occurring or discovered during the term of the Contract for Health Care Services; and

ii. Take immediate action to remove any PMG or other delegated Provider agent that does not meet participation status requirements from furnishing items or services related to the Contract for Health Care Services (whether medical or administrative) to Members.

d. Designate dedicated staff responsible for the timely Credentialing and Recredentialing of all Practitioners; and

e. Credential and Recredential Practitioners, in accordance with CalOptima Policy GG.1609Δ: Credentialing and Recredentialing.

D. Sub-Delegation

1. CalOptima shall not sub-delegate PRB functions and the determination of a Provider's participation in the CalOptima program.

2. A delegated Health Network or other delegated Provider shall not sub-delegate any Credentialing or Recredentialing activity without prior approval from CalOptima.

3. A delegated Health Network or other delegated Provider may only sub-delegate to a credentialing verification organization (CVO) that is certified by NCQA, pursuant to the Contract for Health Care Services. The Health Network or other delegated Provider shall retain ultimate responsibility for any sub-delegated activities.

4. Prior to sub-delegating Credentialing activities to a CVO, Health Network, or other delegated Provider shall evaluate the CVO's capacity to perform such activities according to CalOptima's Credentialing and Recredentialing standards.

5. The sub-delegated activities shall be described in a written Delegation Agreement with the CVO. The agreement between the Health Network or other delegated Provider and a CVO shall include all of the following:

a. The responsibilities of each party;

b. The sub-delegated activities;

c. The process by which CalOptima, a Health Network or other delegated Provider shall evaluate the CVO's performance;

d. The remedies, including revocation of sub-delegation, available to CalOptima or the Health Network or other delegated Provider if the CVO does not fulfill its obligations;

e. A process for regular reports by the CVO to CalOptima or the Health Network or other delegated Provider;

f. Agreement as to the exchange of information between the Health Network or other delegated Provider and the CVO, including a definition of peer review or confidential information, and a process for sharing information with each other and with third parties;

g. A process for handling Protected Health Information (PHI), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) as amended; and

h. A monitoring schedule.

6. A Health Network or other delegated Provider shall be responsible for providing oversight for all sub-delegated Credentialing activities.

7. On an annual basis, the Health Network or other delegated Provider shall evaluate the CVO's Credentialing process. The evaluation shall ensure that the sub-delegated activities are conducted, in accordance with CalOptima's Credentialing standards.

8. The Health Network or other delegated Provider shall submit to CalOptima an annual report documenting the Health Network's or other delegated provider's evaluation process of the sub-delegated function.

9. The Health Network's or other delegated Provider's PRB shall retain the right to approve new Practitioners or sites, and to terminate or suspend individual Practitioners based upon quality issues.

10. CalOptima shall monitor the Health Network's or other delegated Provider's oversight process of the CVO through CalOptima's annual oversight of the Health Network's or other delegated Provider's Credentialing and Recredentialing process.

E. Annual Audit

1. On an annual basis, CalOptima shall perform a substantive evaluation of all Health Network or other delegated Providers with whom CalOptima has delegated activities against contractual standards, in accordance with this policy. The annual audit shall be based on the mutually agreed-upon Delegation Agreement and the appropriate contractual standards.

2. The annual audit shall include the review of policies and procedures utilizing the Delegation Oversight Annual Audit Tool:

    a. A review of Health Network or other delegated Providers PRB meeting minutes, which shall be conducted for Credentialing and Recredentialing activities;

    b. A review to confirm the Health Network's or other delegated Provider's reporting procedure to CalOptima when there is action taken against a Practitioner that relates to professional behavior or clinical competence, and suspensions, terminations, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Health Network's or delegated provider's PRB that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG)).

3. An annual file review is also conducted utilizing the Credentialing and Recredentialing File Review Tool:

    a. CalOptima applies the 8/30 methodology when conducting the Annual File Review. CalOptima will select a random sample of thirty (30) Credentialing and thirty (30) Recredentialing files, and will provide the organization with the file selection.

    b. Eight (8) of each file type will be randomly chosen for the initial review. Credentialing requirements applicable to both file types are scored for all files. CalOptima reviews files until it has sufficient results to score based on the 8/30 methodology.

    c. If the requirement applies only to initial Credentialing files (e.g., work history) or to Recredentialing files (e.g., Recredentialing cycle length), the requirement is scored 'Not Applicable' for the file type that does not apply. CalOptima scores only applicable files until it has sufficient results to score based on its 8/30 methodology.

        i. If fewer than thirty (30) Practitioners were Credentialed or Recredentialed within the look back period, CalOptima shall audit the universe of files rather than a sample.

    d. CalOptima shall review documentation of substantive evaluation and action plans, if needed.

    e. If the Health Network or other delegated Provider does not have any files for Credentialing or Recredentialing between audit cycles, then CalOptima will not need to perform an annual audit, but instead shall require the Health Network or other delegated Provider to meet all other Delegation oversight requirements, and provide documentation that the Health Network or other delegated Provider did not Credential or Recredential Practitioners between audit cycles.

4. Based on the results of the annual audit, CalOptima may take the following actions:

a. Require a Health Network or other delegated Provider to respond to and submit a CAP addressing all areas of deficiency as determined by CalOptima in accordance with CalOptima Policy MA.9104: Corrective Action Plan;

b. Audit the Health Network's or other delegated Provider's implementation and completion of an approved CAP, and any performance area(s) addressed in the CAP;

c. Impose Sanctions against a Health Network or other delegated Provider, in accordance with CalOptima Policy MA.9105: Sanctions;

d. Initiate the de-delegation process in accordance with Section III.G of this policy.

5. CalOptima shall report findings from oversight reviews and CAPs to the DOC, with recommendations for follow-up activities.

F. Health Network De-delegation

1. The Audit & Oversight Credentialing auditor shall review CAPs that do not meet the compliance threshold or are classified as 'delinquent', and shall make appropriate recommendations to the DOC.

2. The DOC shall review the Health Network's or other delegated Provider's Delegation status based on the CAP timeline and level of achievement.

3. If the Health Network or other delegated Provider fails to achieve compliance within the timeframes set forth in the CAP, the DOC may recommend de-delegation of Credentialing and Recredentialing.

4. If the DOC approves de-delegation of Credentialing and Recredentialing activities from the Health Network or other delegated Provider, CalOptima shall:

a. Provide the Health Network or other delegated Provider with thirty (30) calendar days written notice of CalOptima's intent to de-delegate;

b. Inform Providers of the de-delegation and instructions for continued services;

c. Adjust the Health Network's or other delegated Provider's payments as appropriate to the de-delegated status of Credentialing and Re-credentialing activities; and

d. Prepare appropriate CalOptima departments to provide the de-delegated Credentialing and Recredentialing activities.

5. The Health Network or other delegated Provider shall cooperate with CalOptima to ensure smooth transition and continuous care for Members during the de-delegation transition period.

6. CalOptima shall re-evaluate the Health Network's or other delegated Provider's ability to perform delegated Credentialing and Recredentialing activities no less than twelve (12) months after de-delegation.

    a. CalOptima shall utilize the pre-delegation readiness assessment process, as described in Section IV.B of this policy.

    b. CalOptima shall delegate Credentialing and Recredentialing activities to the Health Network or other delegated Provider based on the pre-delegation readiness assessment results.

    c. The Audit & Oversight Management Team shall present the re-audit pre-delegation readiness assessment results to the DOC.

    d. If the DOC approves Delegation of Credentialing and Recredentialing activities to the Health Network or other delegated Provider, CalOptima shall re-delegate such activities, and adjust the Health Network's or other delegated Provider's payment accordingly.

    e. If the DOC denies re-delegation of Credentialing and Recredentialing activities to the Health Network or other delegated Provider, it may recommend additional Sanctions on the Health Network or other delegated Provider, up to and including termination of the Contract for Health Care Services.

G. CalOptima shall inform the Health Network or other delegated Provider and Practitioner's of their right to file an Appeal.

H. Exchange of Information

1. CalOptima may, at its discretion, share with another Health Network or other delegated Provider, copies of a report received from a Health Network or other delegated Provider regarding an adverse action if CalOptima deems that such report may protect the medical care of a Member.

    a. The provision of any such report to another Health Network or other delegated Provider shall not relieve the Health Network or other delegated Provider, or any other entity, of an independent duty to comply with Credentialing procedures or query or file a report with state or federal regulatory agencies.

2. CalOptima retains the right to review all components of a Health Network or other delegated Provider's file.

I. Monitoring

1. CalOptima shall provide ongoing monitoring of a delegated Health Network's or other delegated Provider's Credentialing and Recredentialing activities through reports, monthly file review, and continuous improvement activities.

a. Monthly Credentialing Universe

i. The Monthly Credentialing Universe is due to CalOptima on the second (2nd) day of every month.

a) Universes for each line of business must be submitted via FTP server to the 'HN_Reporting' folder utilizing the instructed naming conventions.

b. Monthly File Review

i. On a monthly basis, CalOptima will review Credentialing and Recredentialing files for each delegate.

a) The CalOptima auditor will select the following file types at random from the Monthly Credentialing Universe submitted:

1. Eight (8) Medicare Credentialing Files; and

2. Eight (8) Medicare Recredentialing Files.

ii. The CalOptima auditor will notify the Health Network or other delegated Provider via email of the file selection no later than the fourth (4th) of every month.

iii. The Health Network or other delegated Provider is required to submit the selected Credentialing and Recredentilaing files to CalOptima on the eighth (10th) of every month.

a) Credentialing and Re-credentialing files for each line of business must be submitted via FTP server into the 'HN_Reporting' folder utilizing the instructed naming conventions.

2. A delegated Health Network or other delegated Provider shall submit reports to CalOptima on a periodic basis, as specified by CalOptima, including, but not limited to, those reports based on the mutually agreed-upon Delegation Agreement.

a. Reports shall include, but are not limited to:

i. Monthly Credentialing and Recredentialing reports;

ii. A lists of all Practitioners with current licensure, Credentialing and Recredentialing dates, Drug Enforcement Administration (DEA) certification, malpractice information, and other specified information;

iii. Verification of Board Certification for Practitioners who claim Board Certification status; and

iv. Annual reports of any sub-delegated entity's performance, if CalOptima approved such sub-delegation.

b. A delegated Health Network or other delegated Provider shall submit such reports to CalOptima, in accordance with the Delegation Agreement.

i. CalOptima shall require:

a) A Health Network or other delegated Provider shall notify CalOptima immediately of any investigation by a regulatory or licensing agency of a Practitioner that relates to professional behavior or clinical competence, and suspensions, terminations, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Health Network's or delegated provider's PRB that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG)).

b) A Health Network, or other delegated Provider shall provide to CalOptima copies of any California Business and Professions Code, Section 805 reports, or National Practitioner Data Bank reports, at the time the report is filed

V. ATTACHMENTS

A. Monthly Credentialing Universe

REFERENCES

A. Contract for Health Care Services
B. California Business and Professions Code, Section 805
C. CalOptima Policy MA.1001: Glossary of Terms
D. CalOptima Policy CMC.1001: Glossary of Terms
E. CalOptima Global Policy GG.1609Δ: Credentialing and Recredentialing
F. CalOptima Policy MA.1616Δ: Fair Hearing Plan for Practitioners
G. CalOptima Policy MA.9104: Corrective Action Plan
H. CalOptima Policy MA.9105: Sanctions

VI. REGULATORY APPROVALS

None to Date

VII. BOARD ACTION

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	08/01/2005	MA.7008	Delegation and Oversight of

Version	Version Date	Policy Number	Policy Title
			Credentialing and Recredentialing Activities
Revision Date 1	03/01/2007	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities
Revision Date 2	09/01/2011	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities
Revision Date 3	09/01/2015	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities

Policy #: MA.9129
Title: **Health Network Claim Processing**
Department: Office of Compliance
Section: Audit & Oversight

CEO Approval: Michael Schrader _____

Effective Date: 07/01/15
Last Review Date: N/A
Last Revised Date: N/A

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect

I. PURPOSE

To ensure Health Network compliance with Claims settlement practices.

II. DEFINITIONS

Term	Definition
Corrective Action Plan (CAP)	A plan delineating specific and identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, or designated representatives. Health Networks and Providers may be required to complete CAPs to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.
Contracted Provider	A Provider who is obligated by a written contract to provide Covered Services to Members on behalf of CalOptima or a Physician Medical Group.
Covered Services	Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract.
Emergency Services	Covered Services furnished by a Provider that are needed to evaluate or stabilize an Emergency Medical Condition
Health Network	For purposes of this policy, a Health Network is a Physician Medical Group, Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.
Non-Clean Claim	A claim for Covered Services that lacks required documentation such as

	medical records or authorization number
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Physician Medical Group.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.

III. POLICY

A. A Health Network shall establish and maintain administrative processes, or contract with a claims processing organization, to accept and adjudicate claims for health care services provided to Members, in accordance with the provisions of this policy and applicable laws and regulations.

B. A Health Network shall ensure timely compliance with claims payment obligation and claims settlement practices

C. Health Network shall not impose a deadline for the receipt of a claim:

   a. For a Non-Contracted provider that is less than twelve (12) months or one (1) calendar year after the date the services were furnished.

   b. For a Contracted Provider that is less than the timeframe specified in the contracted provider agreement. If the contracted provider agreement does not specify a timeframe, the contracted provider shall submit a claim within twelve (12) months, or one (1) calendar year after the date the services were furnished.

D. A Health Network shall identify and acknowledge the receipt of each claim, whether or not it is a Complete Claim, and disclose the recorded date of receipt in the same manner as the claim was submitted. Alternatively, the Health Network may provide an electronic means, by telephone, website, or another accessible method of notification, by which the Provider may readily confirm the Health Network's receipt of the claim and the recorded date of receipt within the timeframes specified in Section III.E of this policy.

E. Claims Processing Timelines

   a. OneCare

      1. A Health Network shall process and adjudicate ninety-five percent (95%) of claims for Covered Services provided to a Member within thirty (30) days after the Health Network's receipt of such Clean Claims.

      2. A Health Network shall process one hundred percent (100%) of claims for Covered Services provided to a Member within sixty (60) calendar days from the day of the request of such Clean Claims.

      3. A Health Network shall adhere to the Medicare Claims Processing Manual for the handling of all incomplete or invalid claims.

b. OneCare Connect Program

1. A Health Network shall process and adjudicate ninety percent (90%) of claims for Covered Services provided to a Member within thirty (30) calendar days after the Health Network's receipt of such Clean Claims.

2. A Health Network shall process ninety-nine percent (99%) of claims for Covered Services provided to a Member within ninety (90) calendar days from the day of the request of such Clean Claims.

F. A Health Network shall not request reimbursement for the overpayment of a claim unless the Health Network sends a written request for reimbursement to the Provider within three hundred and sixty-five (365) calendar days after the date of payment on the overpaid claim. The three hundred and sixty-five (365) calendar day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the Provider.

G. A Health Network shall pay interest and applicable penalties on all Clean Claims not paid within thirty (30) days after the day of receipt of the claim on a per claim basis, in accordance with Section III.D of this policy. The interest rate is determined by Title 31 of the United States Code (U.S. Code), section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date the Health Network makes payment.

H. In the event the Health Network fails to timely and accurately reimburse its claims and the Health Network has not established an approved Corrective Action Plan (CAP) consistent with CalOptima Policies MA.9104: Corrective Action Plan and MA.9105: Sanctions, CalOptima shall take appropriate corrective action, which may include but is not limited to the de-delegation of claims payment.

I. A Health Network shall not improperly deny, adjust, or contest a claim and shall provide a clear and accurate written explanation of the specific reasons for the action taken.

J. A Health Network shall establish and maintain a fair, fast, and cost-effective dispute resolution mechanism to process and resolve Provider disputes that meet the requirements of CalOptima Policy MA.9006: Provider Complaint Process and Title 42, Code of Federal Regulations (CFR) 405.927-405.942. A Health Network shall make all records, notes, and documents regarding its Provider dispute resolution mechanism(s) and the resolution of its Provider disputes available to CalOptima and any requesting regulatory agency.

K. A Health Network shall resolve its Provider disputes in a timely manner, including the issuance of a written decision, in accordance with CalOptima Policy MA.9006: Provider Complaint Process and Title 42, Code of Federal Regulations (CFR) Sections 405.927-405.942. CalOptima shall monitor and ensure the administration of the Health Network's dispute resolution mechanism(s) and for the timely resolution of Provider disputes.

L. A Health Network shall not engage in any practices, policies, or procedures that may constitute a basis for a finding of a demonstrable and unjust payment pattern or unfair payment pattern that results in repeated delays in the adjudication and correct reimbursement of Provider claims.

M. A Health Network shall submit to CalOptima all required claims performance reports within the timeframe and in a format specified by CalOptima. Required reports shall at a minimum, disclose the Health Network's compliance status with the provisions of this policy, the CFR, and CMS requirements.

N. A Health Network shall reimburse a provider for Emergency Services and, if applicable, its affiliated providers for related services at the lowest level of emergency department evaluation and management (Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

IV. PROCEDURE

A. Claim Filing Deadlines

1. A Health Network shall not impose a deadline for the receipt of a claim that is less than ninety (90) calendar days for a Participating Provider and one hundred and eighty (180) calendar days for a Non-Contracting Provider after the date of service, except as required by state or federal law or regulation.

2. If a Health Network denies a claim because it was filed beyond the claim filing deadline, the Health Network shall, upon a Provider's submission of a dispute pursuant to Title 42, CFR sections 405.927-405.942 and the demonstration of good cause for the delay, accept and adjudicate the claim accordingly.

3. If the Health Network is not the primary payer under coordination of benefits, the Health Network shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payer that is less than ninety (90) calendar days from the date of payment or date of contest, denial, or notice from the primary payer.

B. Misdirected Claims

1. For a Provider claim involving Emergency Services that is incorrectly sent to a Health Network, the Health Network shall forward the claim to the appropriate Health Network within ten (10) business days after receipt of the clam.

2. For a Provider Claim that does not involve Emergency Services that is incorrectly sent to a Health Network, and the Provider that filed the claim is a contracted Provider, within ten (10) business days of the receipt of the claim the Health Network shall either:

   a. Send the Provider a notice of denial, within thirty (30) business days, with instructions to bill the appropriate Health Network; or

   b. Forward the claim to the appropriate Health Network

3. In all other cases, for claims incorrectly sent to a Health Network, the Health Network shall forward the claim to the appropriate Health Network within ten (10) business days of the receipt of the claim.

4. If a claim is sent to a Health Network and CalOptima is responsible for adjudicating the claim, the Health Network shall forward the claim to CalOptima within ten (10) business days after the receipt of the claim incorrectly sent to the Health Network.

C. Acknowledgement of Claims

1. In the case of an electronic claim, the Health Network shall identify and acknowledge the claim within two (2) business days after the date of receipt of the claim by the office designated to receive claims. Electronic claims received by 5- p.m. on a business day, or by closing time if the Health Network routinely ends its public business day between 4- p.m. and 5- p.m., must be considered as received on that date.

2. In the case of a paper claim, the Health Network shall identify and acknowledge the claim within fifteen (15) business days after the date of receipt of the claim by the office designated to receive claims. Paper claims received by 5- p.m. on a business day, or by closing time if the Health Network routinely ends its public business day between 4- p.m. and 5p.m., must be considered as received on that date. A paper claim received after the routine close of business between 4 p.m. and 5 p.m. is considered received on the next business day.

3. If a Provider submits a claim using a Health Network's claims clearinghouse, the Health Network's identification and acknowledgment to the clearinghouse within the timeframes set forth in subparagraph 1 and 2 of this section, whichever is applicable, shall constitute compliance.

D. Interest on Late Claims

1. Interest shall begin to accrue on the thirty-first (31st) business day and is calculated based on calendar days. Interest is paid at the rate used for section 3902(a) of Title 3l, U.S. Code and rounded to the nearest penny. The interest rate is determined by the applicable rate on the day of payment. Interest shall be calculated using the following formula:

   a. Payment amount x rate x days divided by 365 (366 in a leap year) = interest payment

2. If the interest due on an individual claim is less than two dollars ($2), a Health Network may wait until the close of the calendar month and make a lump interest payment for all late claim payments during that time period. The Health Network shall make lump interest payments within ten (10) calendar days of the calendar month's end.

E. Denying, Adjusting, or Contesting a Claim

1. A Health Network may contest or deny a claim, or portion thereof, by notifying the Provider, in writing, that the claim is contested or denied, within thirty (30) days after the date of receipt of the claim by the Health Network.

2. If the Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, the Health Network shall provide a clear, accurate, and written explanation of the necessity for the request. If the Health Network subsequently denies the claim based on the Provider's failure to provide the requested Medical Records or other information, any dispute arising from the denial

of such claim shall be handled as a Provider dispute in accordance with Title 42, CFR sections 405.927-405.942.

3. If a Health Network fails to provide the Provider with written notice that a claim has been contested or denied within the allowable time period pursuant to Section IV.E.1 of this policy, or requests information from the Provider that is not reasonably relevant information and requests information from a third party that is in excess of the information necessary to determine payer liability, but ultimately pays the claim in whole or in part, the Health Network shall compute the interest pursuant to Section IV.D of this policy.

4. A request for information necessary to determine payer liability from a third party shall not extend the time for reimbursement or the time for contesting or denying claims. The Health Network shall either contest or deny within the timeframes set forth in Section IV.E.1 of this policy, in writing, incomplete claims and claims for which information necessary to determine payer liability that has been requested, which are held or pended awaiting receipt of additional information. The Health Network shall identify in the denial or contest the individual or entity that was requested to submit information, the specific documents requested and the reason(s) the information is necessary to determine payer liability.

F. Reimbursement for the Overpayment of Claims

1. If a Health Network determines that it has overpaid a claim, it shall notify the Provider, in writing, through a separate notice clearly identifying the claim, the name of the patient, the date of service and including a clear explanation of the basis upon which the Health Network believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

2. If the Provider contests the Health Network's notice of reimbursement of the overpayment of a claim, the Provider, within thirty (30) business days of the receipt of the notice of overpayment of a claim, shall send written notice to the Health Network stating the basis upon which the Provider believes that the claim was not overpaid. The Health Network shall receive and process the contested notice of overpayment of a claim as a Provider dispute pursuant to Title 42, CFR section 405.927-405.942 and CalOptima Policy MA.9006: Provider Complaint Process.

3. If the Provider does not contest the Health Network's notice of reimbursement of the overpayment of a claim, the Provider shall reimburse the Health Network within thirty (30) business days of the receipt by the Provider of the notice of overpayment of a claim.

4. A Health Network may only offset an uncontested notice of reimbursement of the overpayment of a claim against a Provider's current claim submission when:

   a. The Provider fails to reimburse the Health Network within the timeframe in Section IV.F of this policy; and

   b. The Provider has entered into a written contract specifically authorizing the Health Network to offset an uncontested notice of overpayment of a claim from the current claim submissions. In the event that an overpayment of a claim or claims is offset

against a Provider's current claim or claims pursuant to this section, the Health Network shall provide the Provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

G. A Health Network shall provide a participating Provider upon contracting, annually, and upon the Participating Provider's request, the following information in a paper or electronic format, which may include a Website containing this information, or another mutually agreeable accessible format:

1. Directions, including the mailing address, email address, and facsimile number, for the electronic transmission (if available), physical delivery and mailing of claims, all claim submission requirements including a list of commonly required attachments, supplemental information and documentation consistent with reasonably relevant information, instructions for confirming the Health Network's receipt of claims consistent Section IV.C of this policy, and a telephone number for claims inquiries and filing information;

2. The identity of the office responsible for receiving and resolving Provider disputes;

3. Directions, including the mailing address, email address, and facsimile number for the electronic transmission (if available), physical delivery, and mailing of Provider disputes and all claim dispute requirements, the timeframe for the Health Network's acknowledgement of the receipt of a Provider dispute and a telephone number for provider dispute inquiries and filing information;

4. Directions for filing substantially similar multiple claims disputes and other billing or contractual disputes in batches as a single Provider dispute that includes a numbering scheme identifying each dispute contained in the bundled case.

5. Complete fee schedule for the Participating Provider; and

6. Detailed payment policies and procedures and rules and non-standard coding methodologies used to adjudicate claims, which shall unless otherwise prohibited by state law:

   a. When available, be consistent with CPT and Medicare Coding, the standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies, and major credentialing organizations;

   b. Clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments; and

   c. At a minimum, clearly and accurately state the policies regarding the following:

      i. Consolidation of multiple services or charges and payment adjustments due to coding changes;

ii. Reimbursement for multiple procedures;

iii. Reimbursement for assistant surgeons;

iv. Reimbursement for the administration of immunizations and injectable medications; and

v. Recognition of CPT.

H. A Health Network shall provide a minimum of forty-five (45) calendar days prior written notice before instituting any changes, amendments, or modifications in the disclosures pursuant to section IV.G of this policy.

1. A Health Network, with the agreement of the Participating Provider, may utilize alternate transmission methods to deliver any disclosure required by this policy, as long as the participating Provider can readily determine and verify that the required disclosures have been transmitted or are accessible and the transmission method complies with all applicable state and federal laws and regulations.

2. The Health Network shall supplement its electronic transmission with paper communication that satisfies the disclosure requirements pursuant to any limitations on the Health Network's ability to electronically transmit any required disclosures as found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended.

I. Managing Claims for Timeliness Compliance

1. A Health Network shall monitor the paid, denied, and pended claims reports daily to ensure that claims are correctly processed and coded, and that the claims meet the timeline requirements.

2. A Health Network shall ensure that timeliness reports are completed weekly and shall develop specific action plans to address any deficiencies noted in such reports.

3. A Health Network shall provide feedback on any deficiencies noted in a claims audit conducted by the Health Network.

4. A Health Network shall document and maintain action plans related to individual examiners or to the unit as a whole for periodic review by CalOptima or the Health Network.

J. Oversight

1. CalOptima shall conduct routine and as needed Claims audit(s) of a Health Network to ensure a Health Network's compliance with statutory, regulatory, contractual, CalOptima policy and any other requirements related to the program(s).

a. CalOptima shall conduct a readiness assessment of a Health Network prior to the effective date of the Health Network contract.

b. CalOptima shall conduct an annual Claims audit of a Health Network.

c. CalOptima may conduct a Claims audit of a Health Network that changes its management company.

d. CalOptima may conduct additional Claims audits as needed.

2. Scope of Claims audit

a. CalOptima shall at its discretion, determine the scope and timing of its periodic and regular Claims audits.

b. A Claims audit may cover one (1) or more functional departments, processes, or delegated functions.

3. Pre-review communications or notice

a. CalOptima may at its discretion, provide a Health Network with advance notice of a claims audit.

b. Prior to the date of the review, CalOptima shall provide written notification to a Health Network of the following:

i. Date and time of the claims audit;

ii. Areas for review;

iii. Reports and questionnaires that the Health Network shall submit to CalOptima prior to the claims audit; and

iv. Documentation the Health Network shall provide prior to or at the time of the claims audit.

c. CalOptima shall make all audit selections from reports submitted by a Health Network and shall return such reports to the Health Network in a timely manner.

4. Claims audit

a. A Health Network shall ensure that the documents are organized in the order of selection provided by CalOptima and accessible on the day of the Claims audit. CalOptima may request copies of the documents from the Health Network.

b. If a Health Network and its delegates, subcontractors, and partners are unable to furnish all required documents requested by CalOptima by the requested due date, CalOptima may score missing documents as non-compliant.

c. A Health Network shall make staff available during the Claims audit to answer questions and provide necessary information to CalOptima in order to complete the Claims audit.

a. For auditing purposes, a Health Network is considered compliant if a Health Network scores at least ninety-five percent (95%) for timeliness of payment of clean claims for covered services provided to a member within thirty (30) calendar days, and at least ninety-nine percent (99%) of paid claims within ninety (90) calendar days. All other categories shall score at least ninety five percent (95%). For claims payment timelines, a Health Network shall ensure that the requirements of Section III.E of this policy are met. For check cashing, a Health Network shall ensure that at least eighty percent (80%) of checks clear a banking institution within fourteen (14) calendar days after the date the check is mailed. For claims payment timelines, a Health Network shall ensure that the requirements of Section III.E of this policy are met.

6. Report issuance

a. CalOptima shall provide a Health Network with a post-audit letter containing the audit findings and recommendations within thirty (30) calendar days after the completion of the Claims audit.

b. CalOptima shall retain the right to publish data obtained from a Health Network Claims audit, and may distribute such data to a Member or to the general public without further notice to or consent from the Health Network.

7. Action based on a Health Network's Claims audit

a. If CalOptima determines that a Health Network is non-compliant with the provisions of this policy, CalOptima shall conduct a Focused Review within one hundred eighty (180) calendar days after the audit of a Health Network.

b. A Health Network may be required to submit a CAP addressing all areas of deficiency as determined by CalOptima, in accordance with CalOptima Policy MA.9104: Corrective Action Plan.

c. CalOptima may impose remedies such as, but not limited to, de-delegation of claims payment, or may impose sanctions against a Health Network pursuant to CalOptima Policy MA.9105: Sanctions.

d. Findings and CAP(s) from a Health Network's Claims audit shall be reported to the Delegation Oversight Committee with recommendations for follow-up activities and shared as needed with the Compliance Committee.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. Title 42 CFR section 424.44
B. CMS Claims Processing Manual
C. Title 42 C.F.R. Section 422.520
D. Title 31 U.S.C. section 3902(a)
E. CalOptima Policy MA.3103: Claims Coordination of Benefits

F. CalOptima Policy MA.9006: Provider Complaint Process
G. CalOptima Policy MA.9104: Corrective Action Plan
H. CalOptima Policy MA.9105: Sanctions

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

Not Applicable

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	07/01/2015	MA.9129	Health Network Claim Processing

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing Extension of Disposable Incontinence Supplies (DIS) Contracts with Caremax RM Corporation, Schraders' Medical Supply, Inc., and Byram Healthcare Centers; Consider Authorizing Request for Proposal (RFP) Process

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to extend the existing Disposable Incontinence Supplies (DIS) contracts expiring December 31, 2017, with Caremax RM Corporation, Schraders' Medical Supply, Inc., and Byram Healthcare Centers for a one (1) year period; and
2. Authorize the CEO to complete a Request for Proposal (RFP) process for DIS and to select and contract with vendor(s) selected via the RFP process effective January 1, 2019.

Background

Disposable Incontinence Supplies (subject to utilization controls) are covered benefits under the Medi-Cal program and are CalOptima's financial responsibility for CalOptima Direct (COD) members. These supplies include, but are not limited to, disposable diapers and briefs, liners and underpads. The three current providers were contracted through the competitive procurement process in 2009, and the contracts took effect on January 1, 2010. The contracts with extension options, expired on December 31, 2014. Board action taken November 6, 2014 extended the contracts for three additional years through December 31, 2017. Upon review of the performance of the existing vendors, staff has determined that the existing providers are sufficient to meet the current needs of CalOptima members and will continue to be sufficient for the next year.

Due to the time that has elapsed since the last RFP for DIS in 2009, staff recommends that a new RFP be issued for DIS. Therefore, management recommends that the Board authorize extension of the current DIS contracts for a one-year period under the same terms and conditions while staff conducts a competitive procurement process for DIS.

The renewal of the contracts with existing providers will support the stability of CalOptima's contracted provider network and ensure consistent delivery of disposable incontinence supplies. Contract language does not guarantee any provider any particular volume or exclusivity, and allows for CalOptima and the providers to terminate the contracts with or without cause.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2017-18 Operating Budget approved by the Board on June 1, 2017, included approximately $3.9M in expenses related to incontinence supplies. Since rates and terms of the existing contracts for incontinence supplies will remain unchanged through the extension period,

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the recommended action to extend current contracts with incontinence supply providers from January 1, 2018, through June 30, 2018, is a budgeted item with no additional fiscal impact. Management will include expenses related to incontinence supplies for the period July 1, 2018, through December 31, 2018, in the FY 2018-19 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends authorizing the extension of existing contracts with Disposable Incontinence Supplies providers to maintain the current effective provider network and meet member needs while an RFP process is being conducted.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Board Action dated November 6, 2014, Authorize the Chief Executive Officer to Extend Existing Disposable Incontinence Supplies Contracts for an Additional Three Years

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

11/30/2017 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

VI. D. Authorize the Chief Executive Officer (CEO) to Extend Existing Disposable Incontinence Supplies Contracts for an Additional Three Years

Contact

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

Recommended Action

Authorize the CEO to extend existing disposable incontinence supplies contracts expiring December 31, 2014, for an additional 3-year period ending December 31, 2017.

Background/Discussion

Disposable incontinence supplies are a covered benefit under the Medi-Cal program and are CalOptima's financial responsibility for CalOptima Direct (COD) members. These supplies include disposable diapers and briefs, liners and underpads, and related items. The three current providers of these supplies to CalOptima members were awarded contracts based on a competitive procurement process in 2009, and the contracts took effect on January 1, 2010. These contracts, including all extension options, expire December 31, 2014.

Upon review of the performance of the existing vendors, staff determined that the existing providers are sufficient to meet the current needs of CalOptima members. Therefore, management recommends that the Board authorize extension of the current disposable incontinence supplies contracts for a three-year period under the same terms and conditions.

The renewal of the contracts with existing providers will support the stability of CalOptima's contracted provider network and ensure consistent delivery of disposable incontinence supplies. The Board of Directors will continue to preside over contract directives and renewals. Contract language does not guarantee any provider any particular volume or exclusivity, and allows for CalOptima and the providers to terminate the contracts with or without cause.

Fiscal Impact

The recommended action is budget neutral, with no material fiscal impact anticipated to CalOptima.

Rationale for Recommendation

CalOptima staff recommends authorizing the extension of existing contracts with disposable incontinence supplies providers to maintain the current effective provider network and meet member needs.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
None

/s/ Michael Schrader *10/31/2014*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Authorizing Extension of Contract with American Logistics for Non-Medical Transportation Services

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

Recommended Action
Authorize the CEO, with the assistance of legal counsel, to amend CalOptima's contract with American Logistics for non-medical transportation (NMT) for CalOptima Medi-Cal members to extend this agreement through December 31, 2018. All other terms and conditions will remain the same.

Background/Discussion
Medi-Cal managed care plan (MCP) benefits include emergency transportation, non-emergency medical transportation (NEMT) and, prior to July 1, 2017, non-medical transportation (NMT) only for children accessing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. However, AB 2394 (Garcia, 2016) amends the covered outpatient services delineated in Welfare & Institutions Code section 14312 to expressly include NMT for all Medi-Cal members, including adults, effective July 1, 2017, "subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services."

Prior to July 1, 2017, CalOptima contracted with American Logistics to provide taxi servcies for OneCare and OneCare Connect members, as well as Medi-Cal members receiving EPSDT services. The agreement with American Logistics covering transporation to and from EPSDT services was authorized by the CalOptima Board on September 3, 2015, with the contract covering Medicare services authorized by the Board on April 7, 2016 and executed on July 1, 2016. Considering the short lead time between the DHCS's issuance of APL 17-010 on June 29, 2017 and the required implementation date (the following day), CalOptima staff amended the American Logistics contract through March 31, 2018 to broaden the scope of work to include the Medi-Cal NMT benefit to ensure that the benefit was available to members while a longer term solution was being developed. This action was ratified by the Board at the August 3, 2017 meeting.

Also on August 3, 2017, the Board of Directors authorized staff to issue a RFP to solicit bids from vendors to provide NMT services for CalOptima Medi-Cal members with an effective date of April 1, 2018.

Staff is in the process of issuing a RFP. However, staff has determined that more time is needed to issue, assess and identify successful provider(s) to supply NMT services and to implement the services with providers. The Department of Health Care Services (DHCS) has indicated that a Dual Plan Letter will be issued to provide additional guidance regarding NMT services for Cal

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MediConnect plans which has not been released yet. Additional information to address operational concerns has also been provided by DHCS, most recently on November 13, 2017. The enhanced information provided by the State has been instrumental in crafting a statement of work for the RFP. Consequentily, to allow sufficient time for the RFP process while all the updates from DHCS is being incorporated and ensure that there is no disruption to member access to this important transportation benefit, staff is requesteng Board authority to extend the American Logistics contract through December 31, 2018. It is anticipated that contract(s) with the vendor(s) selected through the RFP process will take effect on January 1, 2019.

Fiscal Impact

Because the NMT benefit was added by a DHCS APL 17-010 on June 29, 2017 and took effect the following day, funding for this mandated benefit was not included in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget. Based on draft capitation rates received from DHCS, projected costs for the NMT benefit are approximately $4.83 million for FY 2017-18. Staff anticipates that funding for NMT services will be sufficient to fully cover the costs of the benefit. Management plans to include expenses related to NMT services for the period July 1, 2018, through December 31, 2018, in the FY 2018-19 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends extension of the current contract with American Logistics through December 2018 for NMT services to ensure that CalOptima Medi-Cal beneficiaries have access to this important benefit while the RFP process is being completed.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated September 3, 2015, Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)
2. Board Action dated April 7, 2016, Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016
3. Board Action dated August 3, 2017, Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit
    a. July 17, 2017 DHCS All Plan Letter 17-010 (Revised) Non-Emergency Medical and Non-Medical Transportation Services

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

VIII. F. Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend current OneCare/OneCare Connect taxi services contract for an additional six months from January 1, 2016 through June 30, 2016;
2. Amend budget based on Department of Health Care Services (DHCS) requirements for taxi services for qualifying Medi-Cal children and their caregiver and/or guardian per 2015 EPSDT guidelines for the 2015-2016 fiscal year;
3. Amend contracts with existing taxi services providers to include the Medi-Cal program EPSDT benefit; and
4. Issue a Request for Proposal (RFP) for taxi services for the OneCare, OneCare Connect and Medi-Cal lines of business, and authorize the CEO to contract with vendor(s) selected through this process, with contracts to be effective July 1, 2016 for a two-year term, with three additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background and Discussion

Taxi transportation is a supplemental benefit for OneCare (OC) and a required benefit for OneCare Connect (OCC) members. CalOptima has contracted with American Logistics since January 1, 2008 for services to OneCare members, as a result of an RFP process was conducted in 2007. At its November 6, 2008 meeting, the Board authorized CalOptima's OC Taxi Transportation supplemental benefit, including extension of CalOptima's contract with American Logistics. At its January 2013 meeting, the Board authorized staff to leverage the OC provider network as the basis for the Duals Delivery system, and OCC was added to the current OC contract. The current contract expires December 31, 2015, based on the previous contract extensions.

Currently, the OC and OCC benefits allow for thirty (30) one-way trips per calendar year for each Member. To access this benefit, Members call American Logistics directly and schedule their taxi pick-up in order to receive one-way transportation to their appointment. This is an important benefit for dual eligible beneficiaries, for many of whom availability of transportation may determine whether they are able to obtain appropriate medical services.

The Department of Health Care Services (DHCS), through the EPSDT guidance, requires that non-medical transportation via taxi be made available to qualifying children in the Medi-Cal program. Based on projected membership and expected cost per member per month (PMPM) for Fiscal Year (FY) 2015-16, a budget of $200,000 is requested to meet this requirement, and CalOptima's current

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contract with the taxi provider for OneCare and OneCare Connect are to be amended to include Medi-Cal for the qualifying EPSDT children.
As mentioned above, American Logistics has been the sole taxi provider contracted January 1, 2008 as a result of an RFQ released in 2007. In accordance with vendor management best practices, it is appropriate to complete a new RFP process, with the targeted effective date of new contract(s) of July 1, 2016.

CalOptima's Medical Management and Customer Service staff have reviewed the utilization performance of this provider, evaluated the access needs of CalOptima members, and determined that American Logistics adequately meets CalOptima's requirements for the extended contract period. The extension is requested to allow for an appropriate time frame to complete an RFP process and review all candidates. Therefore, staff recommends extending the current contract for an additional six months, through June 30, 2015.

Fiscal Impact
Based on forecasted OneCare and OneCare Connect enrollment for FY 2015-2016, the fiscal impact of the recommended action to extend the existing OneCare/OneCare Connect taxi services contract for an additional six months from January 1, 2016, through June 30, 2016, is approximately $2,709,863. The recommended action is a budgeted item under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015.

Based on projected membership and expected cost PMPM for qualifying Medi-Cal children enrollment for FY 2015-16, the fiscal impact of the recommended action is expected to be approximately $200,000. This is an unbudgeted item. Funding for this recommended action is expected to be available from anticipated increase in net assets in the current fiscal year.

Rationale for Recommendation
CalOptima staff recommends authorizing an extension to the contract with American Logistics for six months to ensure that OneCare and OneCare Connect members continue to have access to covered services, authorize budget and contract amendment as soon as possible for EPSDT requirement per DHCS, and issuing an RFP for a taxi services effective July 1, 2016 to ensure that members have access to taxi services prospectively.

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 April 7, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Selection of Taxi Vendor and Authorize Contract for Taxi 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 American Logistics to serve as CalOptima's Taxi Vendor for OneCare Connect, OneCare, and Medi-Cal EPSDT members effective July 1, 2016, for a two (2) year term with three (3) additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current taxi services contract for CalOptima's Medicare programs has been in place since January 1, 2008. It was awarded to American Logistics 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 Taxi services for the contract period commencing July 1, 2016.

Following CalOptima's standard RFP process, an RFP was issued and a total of three responses were received.

Discussion
The responses to the RFP were reviewed by CalOptima's evaluation team consisting of the Senior Program Manager for Medicare, Customer Service Director, Customer Service Manager, Executive Director Medical Operations, Contracts Manager, and representatives from the following departments: Finance, Compliance, and Information Services. All vendors were provided a Scope of Work document and the CalOptima base contract at the time of the RFP.

The evaluation team's final weighted scoring for the RFP is as follows:

Vendor	Score
American Logistics	3.96
Access2Care	3.66
Veyo	3.19

Based upon the weighted scores each vendor received, American Logistics finished with the highest score at 3.96 out of a possible 5.0 of the evaluation. Access2Care finished second with a score of 3.66.

American Logistics was the only bidder who proved to have an established transportation network in the Orange County service area.

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Fiscal Impact
Under the terms of the proposed contract, consolidated taxi expenses are projected to decrease 4.9% in the next fiscal year. Management will include expenses associated with the proposed contract in the CalOptima FY 2016-17 operating budgets.

Rationale for Recommendation
CalOptima staff believes that contracting with the highest scoring taxi vendor, American Logistics, will meet the goal of continuing to ensure that CalOptima members receive safe, reliable transportation services in a cost-effective manner. CalOptima staff reviewed qualified taxi vendor responses and identified the candidate believed to best meet CalOptima's needs for safe, reliable, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with the existing taxi 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**

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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

3. Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit

Contact

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

Recommended Actions

1. Ratify amendment to contract with American Logistics expanding the scope of work to include the Medi-Cal covered taxi services benefit, excluding services provided for members assigned to Kaiser Permanente, for nine months beginning July 1, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend other existing contracts through no later than March 31, 2018 as necessary to ensure that qualifying Medi-Cal members have access to covered non-medical transportation services; and
3. Authorize the CEO to conduct a Request for Proposal (RFP) process to solicit bids from vendors providing non-medical transportation for CalOptima Medi-Cal, effective April 1, 2018.

Background

Medi-Cal managed care plan (MCP) benefits include emergency transportation, non-emergency medical transportation (NEMT) and, prior to July 1, 2017, non-medical transportation (NMT) only for children accessing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. However, AB 2394 (Garcia, 2016) amends the covered outpatient services delineated in Welfare & Institutions Code section 14312 to expressly include NMT for all Medi-Cal members, including adults, effective July 1, 2017, "subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services."

On June 29, 2017, the California Department of Health Care Services (DHCS) released All Plan Letter (APL) 17-010 providing MCPs with guidance for NEMT and NMT. Per the APL, beginning July 1, 2017, MCPs were expected to update their NEMT policy and procedures and begin providing NMT for all Medi-Cal members. NMT services include round trip transportation for medically necessary covered and carved-out Medi-Cal services. MCPs are required to provide NMT by passenger car, taxicab, or any other form of public or private conveyance (including private vehicle), as well as gas mileage reimbursement under certain conditions.

Transportation must be physically and geographically accessible and consistent with disability rights laws. One attendant, such as a parent, spouse or guardian may accompany the member. Additionally, a minor can travel without a parent for services which do not require parental consent and otherwise with parental consent.

Prior authorization may, at the discreation of the MCP, be required and reauthorized every 12 months when necessary. When applicable, the MCP is responsible for ensuring that parental consent is obtained in advance of arranging transportation. For NMT requests by private conveyance (e.g.,

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family members, friends, neighbors, etc.), members must attest, in person, by phone, or electronically, that no other methods of transporation are reasonably available and alternatives have been reasonably exhausted. The attestation may include confirmation that the member:

- Has no valid driver's license;
- No working vehicle available in the household;
- Is unable to travel or wait for medical or dental services alone; or
- Has a physical, cognitvie, mental, or developmental limitation.

Reimbursement for private conveyance includes only mileage at the Internal Revenue Service (IRS) standard mileage rates for medical purposes (the 2017 reimbursement rate is $0.17 per mile) and can be made only for drivers compliant with California driving requirements, which includes a valid driver's license, vehicle registration and vehicle insurance. Neither the legislation nor the APL establish any additional specific requirements or criteria for driver eligibility.

Prior to July 1, 2017, CalOptima contracted with American Logistics to provide taxi servcies for OneCare and OneCare Connect members, as well as Medi-Cal members receiving EPSDT services. The agreement with American Logistics covering transporation to and from EPSDT services was authorized by the CalOptima Board on September 3, 2015, with the contract covering Medicare services authorized by the Board on April 7, 2016 and executed on July 1, 2016. Considering the short lead time between the DHCS's issuance of APL 17-010 on June 29, 2017 and the required implementation date (the following day), CalOptima staff amended the American Logistics contract on a short term basis to broaden the scope of work to include the Medi-Cal NMT benefit to ensure that the benefit was available to members while a longer term solution was being developed.

Discussion

CalOptima staff leveraged an existing transportation contract to ensure that the effective date for the new NMT requirement was met. On July 1, 2017, CalOptima began providing the expanded NMT services including the amended contract with American Logistics, as well as via taxi, bus, and private conveyance arranged by members. This benefit is separate from other existing transportation benefits, and members can continue to access emergency and NEMT services in accordance with existing processes. To access NMT services, members can contact CalOptima's Customer Service Department to discuss and coordinate transportation.

Should all other reasonable transportation options be exhausted and private conveyance be required, CalOptima's Customer Service Department will issue a reference number, and members can arrange for their own transportation, with their private drivers submitting gas mileage receipts for reimbursement to CalOptima. In order to receive reimbursement, private drivers will also be required to submit proof that they meet California driving requirements which include valid driver's license, vehicle registration, and evidence of vehicle insurance.

In order to ensure that qualifying Medi-Cal members have access to public conveyance options, bus and taxi services are being offered. CalOptima will continue to procure passes from the Orange County Transit Authority (OCTA) for both bus and OC ACCESS, for members who are unable to use regular bus service due to functional limitations caused by a disability. For taxi services, the

scope of work of the current contract with American Logistics (CalOptima's contracted provider for OneCare and OneCare Connect) has been amended through March 31, 2018 as a short term measure to ensure that this transportation benefit is available to Medi-Cal members.

During this nine month period, CalOptima staff will consider longer term options for providing the NMT benefit and conduct an RFP to identify potential vendors and return to the Board with the RFP results and recommendations. In addition, staff is in the process of developing a comprehensive transportation program, and will be returning to the Board with recommendations and policy updates.

Fiscal Impact
The recommended action to ratify the amendment to the American Logistics contract, amend contracts with existing providers, and conduct an RFP process is expected to result in an increase in both claims and administration expense for CalOptima. However, because non-medical transportation is a newly-mandated benefit and since no projected utilization data has been provided by DHCS, the fiscal impact of this benefit is not currently known. CalOptima staff will continue to work with DHCS to ensure that funding for non-medical transportation will be appropriate and sufficient to fully cover the costs of the benefit. On a prospective basis, staff will update the Board as appropriate on the expenses associated with providing this benefit. Long term, staff anticipates that the program will be budget neutral to CalOptima.

Rationale for Recommendation
CalOptima staff recommends the above actions in order to be compliant with the NMT requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated September 3, 2015, Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)
2. Board Action dated April 7, 2016, Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016
3. July 17, 2017 DHCS All Plan Letter 17-010 (Revised) Non-Emergency Medical and Non-Medical Transportation Services

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

VIII. F. Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend current OneCare/OneCare Connect taxi services contract for an additional six months from January 1, 2016 through June 30, 2016;
2. Amend budget based on Department of Health Care Services (DHCS) requirements for taxi services for qualifying Medi-Cal children and their caregiver and/or guardian per 2015 EPSDT guidelines for the 2015-2016 fiscal year;
3. Amend contracts with existing taxi services providers to include the Medi-Cal program EPSDT benefit; and
4. Issue a Request for Proposal (RFP) for taxi services for the OneCare, OneCare Connect and Medi-Cal lines of business, and authorize the CEO to contract with vendor(s) selected through this process, with contracts to be effective July 1, 2016 for a two-year term, with three additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background and Discussion

Taxi transportation is a supplemental benefit for OneCare (OC) and a required benefit for OneCare Connect (OCC) members. CalOptima has contracted with American Logistics since January 1, 2008 for services to OneCare members, as a result of an RFP process was conducted in 2007. At its November 6, 2008 meeting, the Board authorized CalOptima's OC Taxi Transportation supplemental benefit, including extension of CalOptima's contract with American Logistics. At its January 2013 meeting, the Board authorized staff to leverage the OC provider network as the basis for the Duals Delivery system, and OCC was added to the current OC contract. The current contract expires December 31, 2015, based on the previous contract extensions.

Currently, the OC and OCC benefits allow for thirty (30) one-way trips per calendar year for each Member. To access this benefit, Members call American Logistics directly and schedule their taxi pick-up in order to receive one-way transportation to their appointment. This is an important benefit for dual eligible beneficiaries, for many of whom availability of transportation may determine whether they are able to obtain appropriate medical services.

The Department of Health Care Services (DHCS), through the EPSDT guidance, requires that non-medical transportation via taxi be made available to qualifying children in the Medi-Cal program. Based on projected membership and expected cost per member per month (PMPM) for Fiscal Year (FY) 2015-16, a budget of $200,000 is requested to meet this requirement, and CalOptima's current

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contract with the taxi provider for OneCare and OneCare Connect are to be amended to include Medi-Cal for the qualifying EPSDT children.
As mentioned above, American Logistics has been the sole taxi provider contracted January 1, 2008 as a result of an RFQ released in 2007. In accordance with vendor management best practices, it is appropriate to complete a new RFP process, with the targeted effective date of new contract(s) of July 1, 2016.

CalOptima's Medical Management and Customer Service staff have reviewed the utilization performance of this provider, evaluated the access needs of CalOptima members, and determined that American Logistics adequately meets CalOptima's requirements for the extended contract period. The extension is requested to allow for an appropriate time frame to complete an RFP process and review all candidates. Therefore, staff recommends extending the current contract for an additional six months, through June 30, 2015.

Fiscal Impact
Based on forecasted OneCare and OneCare Connect enrollment for FY 2015-2016, the fiscal impact of the recommended action to extend the existing OneCare/OneCare Connect taxi services contract for an additional six months from January 1, 2016, through June 30, 2016, is approximately $2,709,863. The recommended action is a budgeted item under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015.

Based on projected membership and expected cost PMPM for qualifying Medi-Cal children enrollment for FY 2015-16, the fiscal impact of the recommended action is expected to be approximately $200,000. This is an unbudgeted item. Funding for this recommended action is expected to be available from anticipated increase in net assets in the current fiscal year.

Rationale for Recommendation
CalOptima staff recommends authorizing an extension to the contract with American Logistics for six months to ensure that OneCare and OneCare Connect members continue to have access to covered services, authorize budget and contract amendment as soon as possible for EPSDT requirement per DHCS, and issuing an RFP for a taxi services effective July 1, 2016 to ensure that members have access to taxi services prospectively.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *8/28/2015*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Selection of Taxi Vendor and Authorize Contract for Taxi 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 American Logistics to serve as CalOptima's Taxi Vendor for OneCare Connect, OneCare, and Medi-Cal EPSDT members effective July 1, 2016, for a two (2) year term with three (3) additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current taxi services contract for CalOptima's Medicare programs has been in place since January 1, 2008. It was awarded to American Logistics 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 Taxi services for the contract period commencing July 1, 2016.

Following CalOptima's standard RFP process, an RFP was issued and a total of three responses were received.

Discussion
The responses to the RFP were reviewed by CalOptima's evaluation team consisting of the Senior Program Manager for Medicare, Customer Service Director, Customer Service Manager, Executive Director Medical Operations, Contracts Manager, and representatives from the following departments: Finance, Compliance, and Information Services. All vendors were provided a Scope of Work document and the CalOptima base contract at the time of the RFP.

The evaluation team's final weighted scoring for the RFP is as follows:

Vendor	Score
American Logistics	3.96
Access2Care	3.66
Veyo	3.19

Based upon the weighted scores each vendor received, American Logistics finished with the highest score at 3.96 out of a possible 5.0 of the evaluation. Access2Care finished second with a score of 3.66.

American Logistics was the only bidder who proved to have an established transportation network in the Orange County service area.

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Fiscal Impact
Under the terms of the proposed contract, consolidated taxi expenses are projected to decrease 4.9% in the next fiscal year. Management will include expenses associated with the proposed contract in the CalOptima FY 2016-17 operating budgets.

Rationale for Recommendation
CalOptima staff believes that contracting with the highest scoring taxi vendor, American Logistics, will meet the goal of continuing to ensure that CalOptima members receive safe, reliable transportation services in a cost-effective manner. CalOptima staff reviewed qualified taxi vendor responses and identified the candidate believed to best meet CalOptima's needs for safe, reliable, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with the existing taxi 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**

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: July 17, 2017

ALL PLAN LETTER 17-010 (*REVISED)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION SERVICES

PURPOSE:
This All Plan Letter (APL) provides Medi-Cal managed care health plans (MCPs) with guidance regarding Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. With the passage of Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), the Department of Health Care Services (DHCS) is clarifying MCPs' obligations to provide and coordinate NEMT and NMT services. In addition, this APL provides guidance on the application of NEMT and NMT services due to the Medicaid Mental Health Parity Final Rule (CMS-2333-F)[1]. *Revised text is found in italics.*

BACKGROUND:
DHCS administers the Medi-Cal Program, which provides comprehensive health care services to millions of low-income families and individuals through contracts with MCPs. Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, MCPs are required to establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services. NEMT services are authorized under SSA Section 1902 (a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2.

AB 2394 amended WIC Section 14132(ad)(1) to provide that, effective July 1, 2017, NMT is covered, subject to utilization controls and permissible time and distance standards, for MCP members to obtain covered Medi-Cal medical, dental, mental health, and substance use disorder services. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services and must make their best effort to refer for and coordinate NMT for all Medi-Cal services

[1] CMS-2333-F

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not covered under the MCP contract. Effective October 1, 2017, in part to comply with CMS-2333-F and to have a uniform delivery system, MCPs must also provide NMT for Medi-Cal services that are not covered under the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system.

REQUIREMENTS:

Non-Emergency Medical Transportation
NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code (HSC) Section 1250[2].

MCPs must ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS[3]. MCPs are also required to authorize, at a minimum, the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs. For Medi-Cal services that are not covered by the MCP's contract, the MCP must make its best effort to refer for and coordinate NEMT. MCPs must ensure that there are no limits to receiving NEMT as long as the member's medical services are medically necessary and the NEMT has prior authorization.

MCPs are required to provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services[4]. MCPs are required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches[5]. MCPs shall also ensure door-to-door assistance for all members receiving NEMT services.

Unless otherwise provided by law, MCPs must provide transportation for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, MCPs may arrange NEMT for a minor who is unaccompanied by a parent or a guardian.

[2] 22 CCR Section 51323 (b)(2)(C)
[3] Exhibit A, Attachment 1 (Organization and Administration of the Plan)
[4] 22 CCR Section 51323 (a)
[5] Manual of Criteria for Medi-Cal Authorization, Chapter 12.1 Criteria for Medical Transportation and Related Services

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MCPs must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.

MCPs must provide the following four available modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual[6] and the CCR[7] when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care:

1. MCPs must provide **NEMT ambulance services** for[8]:
    - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
    - Transfers from an acute care facility to another acute care facility.
    - Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
    - Transport for members with chronic conditions who require oxygen if monitoring is required.

2. MCPs must provide **litter van services** when the member's medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following:
    - Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport[9].
    - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[10].

3. MCPs must provide **wheelchair van services** when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
    - Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport[11].

[6] Medi-Cal Provider Manual: Medical Transportation – Ground
[7] 22 CCR Section 51323(a) and (c)
[8] Medi-Cal Provider Manual: Medical Transportation – Ground, page 9, Ambulance: Qualified Recipients
[9] 22 CCR Section 51323 (2)(A)(1)
[10] 22 CCR Section 51323 (2)(B)
[11] 22 CCR Section 51323 (3)(A)

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- Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation[12].
- Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[13].

Members with the following conditions may qualify for wheelchair van transport when their providers submit a signed Physician Certification Statement (PCS) form (as described below)[14]:

- Members who suffer from severe mental confusion.
- Members with paraplegia.
- Dialysis recipients.
- Members with chronic conditions who require oxygen but do not require monitoring.

4. MCPs must provide **NEMT by air** only under the following conditions[15]:
   - When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or mental health or substance use disorder provider.

NEMT Physician Certification Statement Forms

MCPs and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization. In order to ensure consistency amongst all MCPs, all NEMT PCS forms must include, at a minimum, the components listed below:

- Function Limitations Justification: For NEMT, the physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate *without* assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).

[12] 22 CCR Section 51323 (3)(B)
[13] 22 CCR Section 51323 (3)(C)
[14] Medi-Cal Provider Manual: Medical Transportation – Ground, page 11, Wheelchair Van
[15] 22 CCR Section 51323 (c)(2)

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- Certification Statement: Prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested.

Each MCP must have a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their physician by telephone, electronically, in person, or by another method established by the MCP.

Non-Medical Transportation
NMT has been a covered benefit when provided as an EPSDT service[16]. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services. For all Medi-Cal services not covered under the MCP contract, MCPs must make their best effort to refer for and coordinate NMT.

Effective October 1, 2017, MCPs must provide NMT for all Medi-Cal services, including those not covered by the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system.

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Physicians may authorize NMT for members if they are currently using a wheelchair but the limitation is such that the member is able to ambulate without assistance from the driver. The NMT requested must be the least costly method of transportation that meets the member's needs.

MCPs are contractually required to provide members with a Member Services Guide that includes information on the procedures for obtaining NMT transportation services[17]. The Member Services Guide must include a description of NMT services and the conditions under which NMT is available.

At a minimum, MCPs must provide the following NMT services[18]:

- Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle)[19], as well as mileage reimbursement for medical purposes[20] when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.

[16] WIC 14132 (ad)(7)
[17] Exhibit A, Attachment 13 (Member Services), Written Member Information
[18] WIC Section 14132(ad)
[19] Vehicle Code (VEH) Section 465
[20] IRS Standard Mileage Rate for Business and Medical Purposes

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- Round trip NMT is available for the following:
    - Medically necessary covered services.
    - Members picking up drug prescriptions that cannot be mailed directly to the member.
    - Members picking up medical supplies, prosthetics, orthotics and other equipment.
- MCPs must provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

Conditions for Non-Medical Transportation Services:

- MCP may use prior authorization processes for approving NMT services and re-authorize services every 12 months when necessary.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.
- With the written consent of a parent or guardian, MCPs may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. MCPs must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to the MCP in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
    - Has no valid driver's license.
    - Has no working vehicle available in the household.
    - Is unable to travel or wait for medical or dental services alone.
    - Has a physical, cognitive, mental, or developmental limitation.

Non-Medical Transportation Private Vehicle Authorization Requirements

The MCPs must authorize the use of private conveyance (private vehicle)[21] when no other methods of transportation are reasonably available to the member or provided by the MCP. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to the MCP stating other methods of transportation are not available. The attestation can be made over the

[21] VEH Section 465

phone, electronically, or in person. In order to receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include[22]:

- Valid driver's license.
- Valid vehicle registration.
- Valid vehicle insurance.

MCPs are only required to reimburse the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation[23].

Non-Medical Transportation Authorization

MCPs may authorize NMT for each member prior to the member using NMT services. If the MCP requires prior authorization for NMT services, the MCP is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely matter. The MCP's prior authorization process must be consistently applied to medical/surgical, mental health and substance use disorder services as required by CMS-2333-F.

Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards

MCPs are contractually required to meet timely access standards[24]. MCPs that have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 CCR Section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the MCPs from complying with their timely access standard obligations.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including APLs and Dual Plan Letters. MCPs must timely communicate these requirements to all delegated entities and subcontractors in order to ensure compliance.

[22] VEH Section 12500, 4000, and 16020
[23] IRS Standard Mileage Rate for Business and Medical Purposes
[24] 28 CCR Section1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)

If you have any questions regarding this APL, contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Authorizing Extension of the Coordination and Provision of Behavioral Health Care Services Contract Between CalOptima and the County of Orange, Through its Division the Orange County Health Care Agency, that Expires December 31, 2017

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Donald Sharps, Medical Director, Behavioral Health Integration, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO) or his designee, with the assistance of legal counsel, to enter into an amendment to the OneCare and OneCare Connect Coordination and Provision of Behavioral Healthcare Services Contract between CalOptima and the County of Orange through its division the Orange County Health Care Agency (HCA) to extend the agreement through ~~June 30, 2018, with four (4) additional one-year extension options,~~ December 31, 2020, with two (2) one-year options, exercisable upon approval by the CalOptima Board and the County of Orange.

Rev 12/7/2017

Background/Discussion

At the April, 4, 2013 Board of Directors meeting, the Board authorized the CEO to enter into the Coordination and Provision of Behavioral Healthcare Services Contract with the County of Orange for the provision of certain Medicare reimbursable mental health services to OneCare members with a serious and persistent mental illness (SPMI) who require the additional outpatient behavioral health services and supports at a higher level of care funded by Short-Doyle Medi-Cal and the Mental Health Services Act (MHSA).

Based on the January 3, 2013 Board action, this contract was amended in 2013 to add the Duals Demonstration (OneCare Connect) program. Following DHCS instruction dated February 21, 2014 which delayed the program start to July 1, 2014, and a subsequent DHCS delay to July 1, 2015, , the contract was amended again in 2015 to specify that the OneCare Connect program would begin no sooner than July 1, 2015, and that the contract would remain in effect through December 31, 2017.

CalOptima staff is requesting Board approval to extend this contract through June 30, 2018. The contract with the County of Orange is on a fixed term basis requiring a contract amendment for any approved extension. CalOptima staff requests that, the contract term language be modified in a fashion similar to other CalOptima provider contracts. In addition to the extension through June 30, 2018, staff is requesting authority to amend the contract so that it may renew on a fiscal year basis, for four (4) additional one-year terms, each exercisable upon CalOptima Board and County approval.

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Fiscal Impact
The recommended action to authorize the extension of the Behavioral Health Care Services Contract between CalOptima and the Orange County HCA for the OneCare and OneCare Connect programs is expected to be budget neutral.

Rationale for Recommendation
The extension of this contract will support the processes that have been put in place with the Orange County Health Care Agency for the coordination of care and provision of Medicare-covered behavioral health services to ensure that members received needed services. As such, staff requests that the Board authorize amendment of the current Coordination and Provision of Behavioral Healthcare Services Contract as recommended.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated January 3, 2013, Authorize the Chief Executive Officer to Develop a Provider Delivery System in Preparation for Implementation of the Duals Demonstration, Including Related Financial Modeling and Contract Template Development
2. Board Action dated April 4, 2013, Authorize the Chief Executive Officer (CEO) to Contract with the County of Orange and its Subcontracted Providers for the Provision of Certain Behavioral Health Services to OneCare Members with a Serious and Persistent Mental Illness (SPMI) and to Amend CalOptima's Contract with Windstone Behavioral Health (Windstone) to Clarify Its Obligations with Regard to the Provision of Certain Behavioral Health Services to OneCare members with SPMI

/s/ Michael Schrader — *11/30/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 3, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. E. Authorize the Chief Executive Officer to Develop a Provider Delivery System in Preparation for Implementation of the Duals Demonstration, Including Related Financial Modeling and Contract Template Development

Contact

Javier Sanchez, Executive Director, CalOptima Care Network, (714) 246-8400

Recommended Actions

1. Ratify amendments to existing and currently approved OneCare Participating Medical Group (PMG), Hospital and Ancillary medical provider contracts which include the stated intent to participate in the Duals Demonstration, with the final contract terms subject to future Board approval; and
2. Authorize the Chief Executive Officer to expand the provider delivery system for the purpose of preparing for the implementation of the Duals Demonstration, including conducting related financial modeling, development of contract templates with the assistance of legal counsel, and including the following:
    a. Issuing a Request for Proposal (RFP) to seek proposals from health care entities including those not currently contracted with OneCare such as organized medical groups and health plans which desire to contract with CalOptima to provide services as part of the Duals Demonstration through alternative financial/ risk delegation models; and authorize staff to use existing OneCare criteria to evaluate providers' delegation readiness, as applicable, and subject to refinement based on final Duals Demonstration requirements;
    b. If necessary for continuity of care, utilizing the CalOptima Care Network (CCN) to serve Duals Demonstration members through CCN's directly contracted network of providers; and
    c. Authorizing the CEO, with the assistance of legal counsel, to enter into Letters of Intent (LOI) with selected RFP responders memorializing the intent to participate in the Duals Demonstration. The final contract terms are subject to future Board approval, as well as state and federal approval, as required.

1/3/13 Recommended action #2 continued for 30 days.

Background

CalOptima currently serves approximately 74,000 members who are dually eligible for both Medicare and Medi-Cal ("dual eligibles"). The CalOptima Board previously approved CalOptima's intention to partner with both the federal and state governments to establish a Duals Demonstration for dually eligible individuals in Orange County. As a Duals Demonstration Plan, CalOptima would be able to coordinate the full array of health care benefits for dually eligible individuals, including both Medicare covered benefits, Medi-Cal covered wrap-around services and Medi-Cal Long Term Services and Supports.

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At its May 2012 meeting, the CalOptima Board authorized the CEO to complete and submit an application to CMS and the DHCS to obtain designation as a Duals Demonstration. At that time, the Board also authorized the CEO to spend pre-implementation startup costs of not-to-exceed $373,994 to secure the necessary resources to meet regulatory requirements for the development of the Demonstration. The initial application requirements were submitted and staff continues to respond to additional inquiries regarding the application. CMS and DHCS plan to conduct plan readiness assessments in October or November 2012.

While Duals Demonstration details are in the process of being finalized by CMS and DHCS, management's understanding is that the proposed method of enrollment of members into the Demonstration is through passive enrollment of members who do not actively opt out. This is similar to the approach used at the start of CalOptima's OneCare program in 2005. At that time, there were approximately 55,000 dual eligible members in Orange County. Most of these individuals were passively enrolled into OneCare; however, within several months of OneCare's start-up, approximately 75% of these individuals actively disenrolled from the program. While OneCare has experienced steady and consistent growth since inception, it continues to experience the disenrollment of members who are unable to access providers not contracted with OneCare.

Discussion

The potential enrollment for the first year of the Duals Demonstration is projected to be approximately 50,000 Orange County dual eligible members currently in fee-for-service (FFS). Enrollment is scheduled to begin in June 2013 and will continue for 12 months. To ensure member continuity of care to the fullest extent feasible under the Demonstration, CalOptima staff desires to engage providers who already serve dual eligible members in FFS Medicare but have not participated in OneCare to their fullest capacity, do not contract with one of CalOptima's contracted PMGs under the OneCare program, or do not currently contract with CalOptima at all. Inclusion of providers that currently serve members in FFS Medicare would ensure adequate network capacity, geographic coverage and cultural competence and would support member engagement in the Demonstration.

Stakeholder Vetting Process

The Board's Provider Advisory Committee (PAC) recently undertook an input and vetting process that included formation of an ad hoc workgroup to consider options for the duals demonstration provider delivery system and offer guidance regarding provider engagement. The workgroup's recommendations regarding delivery system expansion and options for provider participation were approved by the PAC at its June 14, 2012 meeting. The recommendations have been incorporated into this proposal, summarized in the subsequent section.

The ad hoc workgroup, which includes representatives from hospitals, trade associations CalOptima's contracted health networks, HMOs, some ancillary and DME providers, as well as

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individual medical providers, and other stakeholders continues to meet weekly to develop recommendations to maximize provider participation in the duals demonstration.

Building on CalOptima's OneCare Provider Network

CalOptima was selected to participate in the Duals Demonstration in part because of its experience providing quality of care to dual eligible members in the OneCare program. Staff's proposal is to leverage the OneCare provider network of currently contracted medical groups, hospital and ancillary providers, and additional medical groups approved to participate in the near future, as the basis for the Duals Delivery system. In preparation for the joint CMS and DHCS plan readiness review, staff proposes to leverage existing OneCare contracts. While the final readiness requirements have not been released, staff anticipates that both CMS and DHCS will require plans to provide signed contracts to demonstrate a provider network. For this reason, it is necessary to ratify amendments that were executed with currently contracted PMGs, which state the provider's intent to enter into a contract with CalOptima for the Duals Demonstration subject to the negotiation of final contract terms and Board approval.

Provider Delivery System Expansion

Staff recommends expanding on the existing OneCare delivery system to execute a successful Duals Demonstration that includes as many provider choice options for the 50,000 dual eligibles currently in FFS Medicare as possible. To achieve one of the important the goals of the Demonstration to maintain continuity of care and member/physician relationships for Duals who choose or are passively enrolled in the Dual Demonstration, it is imperative that CalOptima allow flexible options to participate in the Duals Demonstration for providers who currently provide services to Duals outside of CalOptima in Medicare FFS. CalOptima's experience in OneCare from start up indicate that if members are not able to maintain access to providers of their choice, members will exercise their right to disenroll from the Demonstration. The RFP process would allow providers to express their preferred means of participating in the Duals Demonstration:

- Full Delegation/Full Risk (available only in Medi-Cal currently)
- Partial Delegation/Partial Risk – includes Shared Risk (SRG) or Physician Hospital Consortia (PHC) (available in Medi-Cal and OneCare)
- Direct Contract/No Delegation (available only in Medi-Cal currently for limited diagnoses)
- Minimal Delegation (not available currently)

Currently participating delegated medical groups would also have an opportunity to propose new ways to participate in the CalOptima delivery system. For example, current Shared Risk Groups may propose future participation as Full Risk medical groups. Review criteria for such proposals would include evaluation of whether the requesting provider(s) meet the appropriate regulatory risk bearing organization and CalOptima criteria.

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This process would also include the development of a contract template for each contracting option to be provided to interested providers. By offering additional contracting options, CalOptima staff anticipates engaging providers who have not traditionally participated with CalOptima (e.g., Medicare FFS providers), as well as expanding opportunities for currently contracted providers. As an example, two HMOs and three health networks currently contracted in CalOptima's Medi-Cal program are not OneCare providers.

CalOptima would enter into LOIs with providers interested in participating in the Duals Demonstration. Once rates are provided, CalOptima staff intends to develop a provider payment methodology that is based on Medicare rates, subject to final negotiations with DHCS and CMS. The final financial aspects of the Duals Demonstration will be provided to the Board for final approval in conjunction with proposed provider contract terms associated with all contracting options and a proposed agreement with DHCS and CMS.

RFP and Evaluation Process

CalOptima would request proposals (RFP) from medical groups and health plans interested in participating as Full Delegation/Full Risk and Minimal Delegation providers. CalOptima intends to evaluate providers and groups based on their ability to meet the minimum quality, administrative and financial participation criteria. Staff is in the process of developing the formal scoring criteria that will be used to evaluate the RFP responses with the assistance of a M.D. Medical Management consultant specializing in network structure. Such criteria would be approved by the Board and would include, but would not be limited to the following:

1. Medi-Cal Managed care experience
2. A requirement to participate in CalOptima's Medi-Cal and Medicare programs
3. A requirement to serve all CalOptima member categories and ages eligible for health network enrollment
4. Applicants must demonstrate the ability to add new providers not currently participating in the CalOptima system
5. Capacity to service seniors and persons with disabilities
6. Accreditation Status (Hospitals must be Joint Commission accredited)
7. Administrative capacity to perform:
    a. Utilization management
    b. Medical management
    c. Credentialing
    d. Quality management
    e. Claims processing and adjudication
    f. Member services and customer service functions
    g. Electronic data interchange
8. SB 260 compliance
9. Financial solvency

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10. Financial reserve requirements
11. Cultural and linguistic services
12. Coordination with carve-out agencies
13. Demonstrated capacity to provide, or written subcontracts for the provision of, all covered services, as defined in the Division of Financial Responsibility (DOFR) provided by CalOptima
14. A history of quality patient care and member satisfaction as demonstrated through HEDIS or other approved measures

Recognizing the different strengths and weaknesses among the various groups and the need to maintain as many qualified participating providers as possible, CalOptima staff plans to work with health networks and providers independently in an effort to determine the optimal relationship for all parties involved.

Letters of Intent

To secure a robust delivery system and provider network that offers the best opportunity for a successful Duals Demonstration, it is necessary for CalOptima to secure LOIs with providers ahead of the start date of the Demonstration. Due to the lack of rates and final contractual terms associated with the Demonstration, the only option available to CalOptima is to enter into Letters of Intent (LOI) with down-stream providers selected according to the proposed process described above. With assistance of Legal Counsel, CalOptima staff would draft and execute LOI with providers subject to the final contract terms are to be negotiated and subject to future Board approval.

Fiscal Impact

Significant financial analysis will be performed once the rates for the Duals Demonstration are determined. The Board will have the opportunity to assess CalOptima's participation in the Duals Demonstration and the associated delivery system once rates are received. The rates paid to CalOptima are expected to be based on the current medical costs for Dual Demonstration eligibles, with reductions to generate savings to the State and CMS from the program. The rates paid to providers will be based on the rates paid to CalOptima. CalOptima's best opportunity to mitigate financial risks is to achieve the broadest network of physicians and largest number of members possible. The more CalOptima's Duals Demonstration membership is reflective of the Orange County duals population as a whole, then the more likely the payment rates provided under the program will be adequate. CalOptima will be fully financially responsible for duals that may be served in CCN and will implement a coordinated model of care consistent with prevailing managed care principles in Orange County. CalOptima expects to reduce medical expenses and contribute additional margin as it manages these previously unmanaged members to a medical expense per member more similar to medical expense experience in a managed population.

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Rationale for Recommendation

Successful implementation of the Duals Demonstration is predicated in large part on the establishment of a network that includes providers who may not have fully participated with CalOptima or have not contracted with CalOptima previously and are currently providing services for CalOptima dual eligible members in FFS Medicare. To engage these providers, CalOptima recommends the Board consider expanding the Duals Demonstration delivery system to offer a flexible participation model that aligns providers' organizational capacity with their level of desired risk.

Concurrence

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

Attachments

None

/s/ Michael H. Ewing — **Authorized Signature**

12/21/12 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. H. Authorize the Chief Executive Officer (CEO) to Contract with the County of Orange and its Subcontracted Providers for the Provision of Certain Behavioral Health Services to OneCare Members with a Serious and Persistent Mental Illness (SPMI) and to Amend CalOptima's Contract with Windstone Behavioral Health (Windstone) to Clarify Its Obligations with Regard to the Provision of Certain Behavioral Health Services to OneCare Members with a SPMI

Contact

Clayton Chau, M.D., Medical Director, Behavioral Health, (714) 246-8400

Recommended Actions

Authorize the CEO to:

1. Enter into contracts with the County of Orange and its subcontracted providers for the provision of certain Medicare-reimbursable mental health services to OneCare members with a serious and persistent mental illness (SPMI) who require the additional outpatient behavioral health services and supports at a higher level of care funded by Short-Doyle Medi-Cal and the Mental Health Services Act (MHSA).
2. Amend CalOptima's current contract with Windstone to clarify its obligations with regard to the provision of these services.

Background

CalOptima's OneCare HMO SNP program is responsible for mental health services covered by Medicare. CalOptima has delegated responsibility for the coordination and provision of outpatient mental health services to Windstone since the inception of the OneCare program. CalOptima pays Windstone a per-member-per-month (PMPM) capitation payment for covering and coordinating outpatient and inpatient professional services for OneCare members, including discharge planning and transition from the inpatient setting.

Discussion

In 2012, CalOptima identified that it is necessary for OneCare members with a SPMI, who require the additional outpatient behavioral health services and supports at a higher level of care funded by Short-Doyle Medi-Cal and the MHSA through the County of Orange, to receive their care through those programs. Examples of additional services provided through the county programs include socialization activities, recovery support groups, supported housing program, peer led activities, and medication review and education. At any given time, there are approximately 200 OneCare members who require these services.

As proposed, CalOptima will pay the County of Orange and its contracted programs for the Medicare-covered services (directly to the programs) on a fee-for-service (FFS) basis at 80% of the Medicare fee schedule. The programs have agreed to accept this rate. CalOptima will

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continue to pay a capitation payment to Windstone Behavioral Health for OneCare members while the members are receiving the higher level of outpatient care through the County of Orange and its contracted programs. Windstone will have responsibility for inpatient professional services for these members, including discharge planning and transition from the inpatient setting. In addition, Windstone will coordinate with the County of Orange and its contracted programs for transition to the community level of outpatient care when the member has reached the appropriate level of recovery. Windstone's capitation payments have been adjusted to account for the services paid to the County of Orange and its subcontracted providers on a FFS basis.

CalOptima is currently in discussions with the County of Orange to enter into a formal contract to establish the terms of this agreement to provide services to SPMI members. As proposed, in the meantime, CalOptima will continue to pay for these services on a non-contracted out-of-network FFS basis. CalOptima is also in the process of amending Windstone's current contract to stipulate its responsibilities for coordinating the care of OneCare members who receive outpatient mental health services through the County of Orange and its subcontracted providers.

Fiscal Impact
Payments for these programs during 2012 were less than $100,000. While increased volume is expected based on improved access, minimal financial impact is expected since the FFS payments to the County of Orange and its subcontracted providers is offset by the capitation rate change to Windstone.

Rationale for Recommendation
The proposed approach provides OneCare members with access to the most appropriate level of care in a manner that is seamless to them and based on their clinical need. Access to the Medi-Cal and MHSA-funded components provides OneCare members with the best opportunity for recovery, leading to the combined outcome of a healthier member and reduced system costs.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *3/29/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Approval of Proposed New Behavioral Health Policies and Forms to Support the Administration of Behavioral Health (BH) Services for Medi-Cal Members Within CalOptima Internal Operations

Contact

Donald Sharps, M.D., Behavioral Health Medical Director, (714) 246-8400

Recommended Actions

1. Approve CalOptima Policy GG:1548, Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder; and
2. Approve CalOptima Policy GG:1549, Authorization for Psychological Testing for Mental Health Condition

Background

CalOptima currently contracts with Human Affairs International of California, Inc., dba Magellan Healthcare (Magellan) as its Managed Behavioral Health Organization serving Medi-Cal, OneCare, and OneCare Connect members. On September 7, 2017, the Board approved the integration of administration of Medi-Cal covered BH, which includes Mental Health (MH) and Applied Behavior Analysis (ABA) services, within CalOptima internal operations effective January 1, 2018. As part of the implementation process, CalOptima staff has reviewed all relevant policies and identified the need to develop two new ones to address the utilization management of psychological testing and ABA services.

The following Policies and associated forms are being presented, requiring CalOptima Board approval:

	Policy No./Name	Summary/Reason for New Policy
1.	GG.1548: Applied Behavioral Analysis for Autism Spectrum Disorder	• New Policy developed to ensure an ABA policy and process is developed for the assumption of Behavioral Health Services by CalOptima effective 1/1/18 • This policy addresses processes for ABA services eligibility, medical necessity criteria, prior authorization rules, and information related to appeals and grievances • Attached Behavioral Health- Authorization Referral Form (BH-ARF) form for authorization of ABA services
2.	GG.1549: Authorization for Psychological	• New Policy developed to ensure a Psychological Testing policy and process is developed for the assumption of Behavioral Health Services by CalOptima effective 1/1/18

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	Testing for Mental Health Conditions	• This policy addresses processes and criteria to meet eligibility for Psychological Testing, prior authorization and grievances and appeals process • Attached Psychological Testing Request Form for authorization of Psychological Testing services

Fiscal Impact
There is no anticipated fiscal impact.

Rationale for Recommendation
CalOptima staff has developed two new policies, GG.1548 and GG.1549, to ensure a clear process exists for prior authorization of services specifically related to behavioral health benefits, e.g. psychological testing for mental health conditions and applied behavioral analysis for autism spectrum disorder services. Both policies support the integration of administration of Medi-Cal BH services into CalOptima's operations and help to ensure compliance with applicable regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Policy GG.1548: Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder
2. Policy GG.1549: Authorization for Psychological Testing for Mental Health Conditions
3. Board Action dated September 7, 2017, Consider Further Actions Related to the Provisions of Behavioral Health Services for CalOptima Medi-Cal Members

/s/ Michael Schrader — *11/30/2017*
Authorized Signature — **Date**

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Policy #:	GG.1548
Title:	**Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy defines the process by which CalOptima Members may obtain Medically Necessary Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder (ASD) and to provide guidance to Providers on Prior Authorization requirements for the provision of Behavioral Health Treatment (BHT) services to Medi-Cal beneficiaries under twenty-one (21) years of age diagnosed with Autism Spectrum Disorder (ASD).

II. POLICY

A. CalOptima shall provide ABA services to eligible Medi-Cal Members when Medically Necessary and in accordance with CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, Title 22, California Code of Regulations (CCR), Section 51340, and Department of Health Care Services (DHCS) All Plan Letter (APL) 15-025: Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder.

B. A Member shall be eligible to receive ABA services, if all the following criteria are met:

1. The Member is under age twenty-one (21); and
2. If under three (3) years of age, must have provisional diagnosis 954-2300.

C. Prior Authorization for initial requests for ABA services shall include:

1. A licensed medical professional or licensed psychologist diagnosis of ASD;

2. A licensed medical professional or licensed psychologist recommendation for evidenced-based ABA services;

3. A previously authorized Functional Behavior Assessment (FBA) that identifies:

   a. Using validated assessment tools (e.g. Vineland, ABAS), the Member's age-specific impairments such as:

      i. Persistent deficits in social communication and social interaction that have been identified as deficient relative to age expected norms;

      ii. Significant restricted, repetitive patterns of behavior or interests; and

      iii. Significant property destruction or aggression related to the Member's ASD.

b. Antecedents, consequences, and reinforcers that maintain the behavioral impairments; and

c. Possible functions of the behavioral impairments.

4. Documentation which describes the Member-specific treatment plan that includes:

a. The identified behavioral, psychological, family, and medical concerns;

b. Measurable goals in objective and measurable terms based on standardized assessments that address the behaviors and impairments for which the intervention is to be applied. For each goal, baseline measurements, progress to date and anticipated timeline for achievement based on both the initial assessment and subsequent interim assessments over the duration of the intervention; and

c. Information that identifies the delivery of ABA services by a Qualified Autism Service Provider, aligned with provisions set forth in All Plan Letter (APL) 15-025: Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder and defined in Health and & Safety Code Section 1374.73(c)(3),

5. The Member is medically stable;

6. The Member is without need for twenty-four (24)-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities;

7. The ABA services are necessary to correct or ameliorate defects related to ASD, and are generally accepted by the medical community as effective and proven treatments for ASD; and

8. The predicted beneficial outcome of the services outweighs potential harmful effects of ABA such as prompt dependence.

D. Prior Authorization for continuation of ABA services requires that the following information be submitted:

1. The Member has met the following criteria related to the initial course of ABA:

a. A licensed medical professional or licensed psychologist continues to diagnose ASD;

b. A licensed medical professional or licensed psychologist continues to make a recommendation for evidenced-based ABA services;

c. The Member-specific treatment plan has been updated and submitted every six (6) months by the ABA provider or more frequently when warranted by the individual circumstances;

d. The anticipated timeline for achievement of each goal in the Member-specific treatment plan has been based on both the initial assessment and subsequent interim assessments;

e. the Member-specific treatment plan includes measures of progress for each goal using validated assessments of adaptive functioning;

f. There has been documentation of caregivers continued participation in the treatment and demonstration of the ability to apply those skills in naturalized settings;

g. Improvements toward developmental norms and behavior goals cannot be maintained if care was reduced;

h. Behavior issues are not exacerbated and have not become dependent on prompts by the treatment process; and

i. The Member has the required cognitive capacity to benefit from the care provided and to retain and generalize treatment gains.

2. Documentation of ongoing coordination of care and communication with the Member's medical provider; and

3. Documentation of ongoing coordination of care and communication with the member's Local Education Agency, as applicable.

4. Information that identifies the delivery of ABA services by a Qualified Autism Service Provider.

E. If a request for ABA services is denied or modified on the basis that the services are not Medically Necessary, and the Member, Authorized Representative, or provider appeals the decision, the decision shall be subject to review in accordance with CalOptima Policies GG.1507: Notification Required for Covered Services Requiring Prior Authorization, GG.1510: Appeals Process for Decisions Regarding Care and Services, and HH.1108: State Hearing Process and Procedures.

F. Discharge from ABA services are based on the following criteria:

1. Functional improvement is sufficient;

2. Symptom relief is sufficient;

3. Risk status is minimized for dangerousness or property destruction;

4. Continued clinical benefit is not expected from the services being rendered and care is judged no longer appropriate as:

a. Behavioral issues are exacerbated by the treatment;

b. Member is unlikely to maintain gains from continued care;

c. Member does not demonstrate progress towards goals for successive authorization periods;

d. The services being used in the treatment of ASD are not evidence-based practices;

e. The services being rendered provide or coordinate respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan;

f. The services, supplies or procedures are performed in a non-conventional setting including, but not limited to, resorts, spas and camps;

g. The sole purpose of the treatment is vocationally or recreationally-based;

h. the services could be provided by persons without professional skills or training to maintain the beneficiary's or anyone else's safety; and

i. the services are being rendered by a parent, legal guardian or legally responsible person.

IV. ATTACHMENTS

A. Behavioral Health - Authorization Request Form (BH-ARF)

V. REFERENCES

A. American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with autism spectrum disorder. February, 2014
B. BACB Applied Behavior Analysis Treatment of ASD Practice Guidelines for Healthcare Funders and Managers, 2016
C. Blumberg, Stephen, et al, Diagnosis lost: Differences between children who had and who currently have an autism spectrum disorder diagnosis. Autism 1-13, 2015
B. California Welfare and Institutions Code, Section 14132
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
C. CalOptima Policy GG1113: Referral Practitioner Responsibilities
D. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
E. CalOptima Policy GG.1508: Authorization and Processing of Referral
F. CalOptima Policy GG1507: Notification Required for Covered Services Requiring Prior Authorization
G. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
H. CalOptima Policy GG.1535: Utilization Criteria and Guidelines
I. CalOptima Policy HH.1102: CalOptima Member Complaint
J. CalOptima Policy HH.1108: State Hearing Process and Procedures
K. Christine Fountain, Alix S. Winter and Peter S. Bearman. Six Developmental Trajectories Characterize Children With Autism. Pediatrics 129, May 1, 2012
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-025: Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder
M. Health & Safety Code, Section 1374.73American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May, 2013
N. Lovaas, O. I., Behavior treatment and normal educational and intellectual functioning in young autistic recipient. Journal of Consulting and Clinical Psychology, 55, 3-9, 1987

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O. MCG 21st Ed Applied Behavioral Analysis ORG: B-a12-AOP (BHG)
P. Title 22, California Code of Regulations (C.C.R.), § 51340

B. REGULATORY AGENCY APPROVALS

None to Date

C. BOARD ACTIONS

12/07/17: Regular Meeting of the CalOptima Board of Directors

D. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2018	GG.1548	Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder	Medi-Cal

E. GLOSSARY

Term	Definition
Applied Behavior Analysis (ABA)	Applied Behavior Analysis refer to the use of behavioral learning principles (i.e. behavior-consequence paradigm) to produce changes in behavior, specifically the development of skills in areas of need (e.g. language) and the reduction in maladaptive behaviors (e.g. aggression, self-injury). ABA therapy may be comprehensive in nature, teaching adaptive techniques to address multiple behavioral and functional concerns, or may be problem-focused and targeted towards addressing specifically identified problematic behaviors (e.g. aggression). (MCG Behavioral Health 21st Edition)
Authorized Representative	Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Autism Spectrum Disorder (ASD)	ASD is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome.
Behavioral Health Treatment (BHT)	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence based behavior intervention programs that develop, restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior
Functional Behavior Assessment (FBA)	By gathering data and conducting experiments that evaluated the effects of environmental variables on the behavior, evaluators decipher the meaning of the behaviors (i.e., what emotion or message was being communicated through the actions), determine why they were occurring, and develop behavior change programs to help the disabled individual display more appropriate behavior in meeting his or her needs.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Qualified Autism Service Provider	A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

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Medi-Cal

P.O. BOX 11033 ORANGE, CA 92856 **Phone: 855-877-3885**

Behavioral Health-Authorization Request Form (BH-ARF)

☐ **ROUTINE** **Behavioral Health Fax: 714-954-2300**

***** IN ORDER TO PROCESS YOUR REQUEST, BH-ARF MUST BE COMPLETE AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment. ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ ☐ **M** ☐ **F** **D.O.B.** _____ **Age:** _____
Last **First**

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

Client Index # (CIN): _____

Referring Provider:	**Provider Rendering Service (Physician, Facility, Vendor):**
Provider NPI#: _____ **TIN#:** _____ **Medi-Cal ID#:** _____	**Provider NPI#:** _____ **TIN#:** _____ **Medi-Cal ID#:** _____
Address: **Phone:** _____ **Fax:** _____	**Address:** **Phone:** _____ **Fax:** _____
Office Contact: _____ **Physician's Signature:** _____	**Office Contact:** _____
Diagnosis: _____	**ICD-10:** _____

AUTHORIZATION REQUEST

List ALL procedures requested along with the appropriate CPT/HCPCS. Supporting Documentation to include:

For Applied Behavior Analysis:
- Functional Behavioral Analysis Report
- Comprehensive Diagnostic Evaluation
- PCP, Local Education Agency, ST/OT/PT Communications

For Testing and Report:
- Psychological Testing Request Form

REQUESTED PROCEDURES	**CODE (CPT or HCPCS)**	**QUANTITY (REQUIRED)**
For Applied Behavior Analysis (Request in hours per week/month)		
Mental Health assessment, by non-physician	H0031	
Mental Health service plan development by non-physician (Non-BCBA)	H0032-HN	
Mental Health service plan development by non-physician (BCBA)	H0032-HO	
Skills training and development	H2014	
Therapeutic behavioral services	H2019	
Home care training to home care client	S5108	
Home care training, family	S5110	
Testing and Reports		
Psychological Testing (number of hours)	96101	
Neurobehavioral status exam	96116	
Neuropsychological Testing (number of hours)	96118	
Other (Please provide CPT code)		

Policy #: GG.1549
Title: **Authorization for Psychological Testing for Mental Health Conditions**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 01/01/18
Last Review Date: Not Applicable
Last Revised Date: Not Applicable

I. PURPOSE

This policy defines the process by which CalOptima Members may obtain Medically Necessary Psychological Testing for Mental Health Conditions.

II. POLICY

A. CalOptima shall provide Psychological Testing to Members when Medically Necessary, and after submission of a CalOptima Behavioral Health Authorization Request Form by the psychologist who has evaluated the Member.

B. Criteria for Medical Necessity for Psychological Testing is based on the most current guidelines pursuant to CalOptima Policy GG.1535: Utilization Criteria and Guidelines.

C. Psychological Testing excludes educational testing or testing requested by the legal system.

D. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies GG.1510: Appeals Process for Decisions Regarding Care and Services, HH.1102: CalOptima Member Complaint, and HH.1108: State Hearing Process and Procedures.

III. PROCEDURE

A. CalOptima shall ensure that, unless otherwise excluded, all Psychological Testing for Medi-Cal Members are provided by CalOptima's Behavioral Health Providers.

B. CalOptima's Behavioral Health Providers shall submit Prior Authorization requests for Psychological Testing, in accordance with this policy.

C. Prior Authorization criteria for Psychological Testing requires all of the following:

1. Be clinically indicated to evaluate a mental health condition;

2. An evaluation by a psychiatrist or psychologist to identify specific diagnostic questions of concern;

3. Tests must be published, valid, and in general use as evidenced by their presence in the current edition of the Mental Measurement Yearbook, or Tests in Print or Most Current Edition by their

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conformity to the Standards for Educational and Psychological Tests of the American Psychological Association;

4. Testing is not routine (e.g., a standard test battery administered to all new members); and

5. Tests are administered by a licensed psychologist and or other clinician for whom testing falls within the scope of their clinical license and who has specialized training in psychological testing.

D. If a request for Psychological Testing is denied on the basis that the services are not Medically Necessary, and the Member, the Member's Authorized Representative, or provider appeals the decision, the decision shall be subject to review in accordance with CalOptima Policies GG.1510: Appeals Process for Decisions Regarding Care and Services, and HH.1108: State Hearing Process and Procedures.

III. ATTACHMENTS

A. Authorization Request Form (ARF)
B. Psychological Testing Request

IV. REFERENCES

A. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May, 2013
B. CalOptima Policy GG.1113: Referral Practitioner Responsibilities
C. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
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F. CalOptima Policy GG.1535: Utilization Criteria and Guidelines
G. CalOptima Policy HH.1102: CalOptima Member Complaint
H. CalOptima Policy HH.1108: State Hearing Process and Procedures
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 13-021: Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services
J. MCG 21st Ed Psychological Testing B-807-T
K. MCG 21st Ed Neuropsychological Testing B-805-T
L. Title 22, California Code of Regulations, § 51340

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2018	GG.1549	Authorization for Psychological Testing for Mental Health Conditions	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Medical Necessity/Medically Necessary	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Mental Health Conditions	Disorders that affect your mood, thinking and behavior.
Psychological Testing	Psychological Testing is the use of standardized assessment tools to gather information relevant to a member's intellectual and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall cognitive functioning related to a member's mental health or substance use status. Test results may have important implications for treatment planning

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Last **First**

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Client Index # (CIN): _____

Referring Provider:	**Provider Rendering Service (Physician, Facility, Vendor):**
Provider NPI#: _____ **TIN#:** _____ **Medi-Cal ID#:** _____	**Provider NPI#:** _____ **TIN#:** _____ **Medi-Cal ID#:** _____
Address: **Phone:** _____ **Fax:** _____	**Address:** **Phone:** _____ **Fax:** _____
Office Contact: _____ **Physician's Signature:** _____	**Office Contact:** _____
Diagnosis: _____	**ICD-10:** _____

AUTHORIZATION REQUEST

List ALL procedures requested along with the appropriate CPT/HCPCS. Supporting Documentation to include:

For Applied Behavior Analysis:
- Functional Behavioral Analysis Report
- Comprehensive Diagnostic Evaluation
- PCP, Local Education Agency, ST/OT/PT Communications

For Testing and Report:
- Psychological Testing Request Form

REQUESTED PROCEDURES	**CODE (CPT or HCPCS)**	**QUANTITY (REQUIRED)**
For Applied Behavior Analysis (Request in hours per week/month)		
Mental Health assessment, by non-physician	H0031	
Mental Health service plan development by non-physician (Non-BCBA)	H0032-HN	
Mental Health service plan development by non-physician (BCBA)	H0032-HO	
Skills training and development	H2014	
Therapeutic behavioral services	H2019	
Home care training to home care client	S5108	
Home care training, family	S5110	
Testing and Reports		
Psychological Testing (number of hours)	96101	
Neurobehavioral status exam	96116	
Neuropsychological Testing (number of hours)	96118	
Other (Please provide CPT code)		

PSYCHOLOGICAL TESTING FORM

This form should be completed by the clinician who has a thorough knowledge of the member's current clinical situation and/or treatment history.

All psychological testing requests must be pre-authorized using this form. Requests for testing should be made only after a comprehensive clinical evaluation has been conducted. This evaluation would normally included direct clinical interviews, relevant history, a review of prior evaluations and testing and contact with the member's school personnel (teacher, guidance counselor), etc. if member is a child. Please note that psychological testing conducted primarily for educational or legal reasons is not a covered service.

This form should be attached to the CalOptima Authorization Request.

****Services performed without prior authorization, or authorization requests that are received after the date of testing, will not be approved.**

Date psychological comprehensive clinical evaluation completed (required): _____

Member Name: _____ D.O.B.: _____/_____/_____

Plan ID Number: _____

Name and discipline of referring clinician (please indicate if you are a Developmental/Behavioral Pediatrician):

Provider Agency & Phone #: _____

Name of Psychologist/Provider who will do testing (if known): _____

Testing Agency & Phone # _____
Provider ID # _____
NPI #_____

This request was submitted by: Referring Clinician _____ or Psychologist who will do testing _____

What are the member's current symptoms? _____
Is the member currently in outpatient treatment? ◯ Yes ◯ No
Date OP treatment began: _____

Please list specific question(s) to be addressed by psychological testing:

- _____
- _____
- _____

Please list what has been done to date to answer these clinical question(s) prior to requesting psychological testing (please be specific):

- _____
- _____
- _____

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How will results of psychological testing facilitate treatment goals and/or provide information beyond what is currently available? (**please be specific**)

- _____
- _____
- _____

Has the member had psychopharmacological consultation? ◯ Yes ◯ No

By whom? _____

Academic issues (if applicable): _____

- Special Education? ◯ Yes ◯ No
- IEP ? ◯ Yes ◯ No
- Dates of any previous psychological or neuropsychological testing _____

Medical issues (including any known pregnancy/birth complications, brain injury, head trauma, lead poisoning):

- _____
- _____

History of Substance Use/Abuse: ◯Yes ◯ No

- If Yes, what substances? _____
- Last use? _____
- Age at first use: _____

Diagnosis: Axis I _____ ICD-10 _____

Please list the psychological tests requested with time required for administration and scoring (in 1 hour units):

_____ = hr(s) _____ = _____hr(s) _____ = _____ hr(s)
_____ = hr(s) _____ = _____hr(s) _____ = _____ hr(s)
_____ = hr(s) _____ = _____hr(s) _____ = _____ hr(s)

Please check one:

- ◯ 96101 Psychological Testing [includes assessment or personality and intellectual abilities, e.g. WAIS-R, Rorschach, TAT, MMPI]
- ◯ 96118 Neuropsychological Testing by Psychologist

Total Units [Hours] Requested: _____

Dates requested for testing: From _____/_____/_____ To _____/_____/_____

Best time and phone number to reach psychologist if needed? _____

Signature of clinician completing request: _____ Date: _____

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Further Actions Related to the Provision of Behavioral Health Services for CalOptima Medi-Cal Members

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400
Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to:
    a. Integrate Medi-Cal covered Behavioral Health (BH), which includes Mental Health (MH) and Applied Behavior Analysis (ABA) services, within CalOptima internal operations effective January 1, 2018;
    b. Establish a standard CalOptima provider fee schedule for MH and ABA services;
    c. Enter into contracts, with the assistance of legal counsel, with MH and ABA providers;
    d. Enter into an agreement, with the assistance of legal counsel, for after-hour coverage for CalOptima's behavioral health call center and triage services obtained in accordance with CalOptima's Procurement Policy;
2. Authorize reallocation of budgeted funds not to exceed $4.1 million from Medi-Cal administrative expenses for purchased services approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, to Medi-Cal medical and administrative expenses; and
3. Authorize unbudgeted expenditures of up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses.

Background

Medi-Cal MH/ABA Benefits. Behavioral Health services include MH, substance use disorder, and autism spectrum disorder behavioral health treatment (which includes ABA services). Outpatient mild-to-moderate MH services became a covered benefit for Medi-Cal managed care plans as of January 1, 2014. Beginning in September 2014, CalOptima started providing ABA services to Medi-Cal beneficiaries under the age of 21 under the Early and Periodic Screening, Diagnostic, and Treatment benefit. Like many Medi-Cal managed care plans, CalOptima has contracted with Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of behavioral health benefits, including ABA. CalOptima currently contracts with Human Affairs International of California, Inc., dba Magellan Healthcare (Magellan) as its MBHO serving Medi-Cal, OneCare, and OneCare Connect members.

Medi-Cal MH/ABA MBHO. Between January 1, 2014 and December 31, 2016, CalOptima contracted with College Health IPA (CHIPA) and its subcontractor Beacon Health Options as its Medi-Cal MBHO. Effective January 1, 2017, the Medi-Cal MH/ABA services were transitioned to Magellan. Magellan was selected as the new MBHO through a 2016 request for proposal (RFP) process that focused on identifying a delivery model that could cover Behavioral Health services for CalOptima's

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Medi-Cal, OneCare, and OneCare Connect members. On September 1, 2016, the Board authorized a contract with Magellan, effective January 1, 2017, for the full scope Medi-Cal covered mild to moderate mental health and ABA services. Specialty mental health services, including inpatient psychiatric services, remain the responsibility of the Orange County Health Care Agency. In addition, substance use disorder treatment services remain as a carve-out benefit under Drug Medi-Cal. CalOptima provides the coordination of care and service across levels of care (including participating on interdisciplinary care teams), quality initiatives, and oversight. The Board also authorized a separate contract with Magellan for Medicare Behavioral Health services for CalOptima's Medicare Advantage (OneCare) and Cal-MediConnect (OneCare Connect) members.

Magellan Contract. The CalOptima-Magellan contract includes a provision allowing for the reset of reimbursement rates for ABA services based on changes to the Medi-Cal membership or the penetration rate for ABA services. In accordance with the contract, Magellan requested an adjustment to the ABA rates based on the increased Medi-Cal member utilization trends. The parties were unable to reach an agreement when on June 28, 2017, CalOptima received a rescission notice from Magellan asserting the right to rescind the Medi-Cal MBHO Contract effective June 30, 2017, rather than providing the 180-notice of termination provided for in the contract. Subsequently, Magellan entered into a "Settlement Agreement and Order" with the Department of Managed Health Care under which Magellan agreed to provide MBHO as set forth in the Medi-Cal Contract from July 1, 2017 through August 30, 2017.

On August 3, 2017, the Board authorized an amendment to the Magellan contract to transition to a percent of premium basis for compensation of ABA services as part of a 180-day wind down period of the contract ending on December 31, 2017. And while staff sought Board authorization to bring administration of the behavioral health benefit in-house, before the Board considered that option, the Chair appointed an ad hoc comprised of Supervisor Do, Vice Chair Penrose, and Director Khatibi to consider available options, including the possibility of extending the current contract with Magellan beyond December 31, 2017.

Discussion

Ahead of the CalOptima Board's August meeting, staff assessed various options for providing MH and ABA services to Medi-Cal members after the transition date with the intent of keeping the provider network intact to mitigate disruptions to services. The network includes over 530 provider contracts that comprises over 800 MH and 300 ABA providers. Following the August CalOptima Board meeting, the ad hoc has met, considered options, and provided direction to staff, including continuing discussions with Magellan. As of the time for finalization and distribution of meeting materials for the September 7, 2017 CalOptima Board meeting, no agreement had been reached with Magellan.

Consequently, the ad hoc has considered various options for moving forward, including considering contracting with another MBHO who responded to the 2016 RFP, issuing a new RFP, contracting with the previous MBHO, outsourcing certain services, or integrating administration of MH and ABA services into CalOptima operations. After considering these options, in the event that agreement with Magellan cannot be reached, the recommended approach is to implement a model in which coordination and management of MH and ABA services are integrated into CalOptima operations rather than utilizing a vendor/partner for Medi-Cal MH/ABA services as the approach that will best

mitigate disruption to Medi-Cal members. While the proposal is to bring administration of this benefit in-house, services will continue to be provided by private sector providers. At this time, no recommendation is being made on the separate contract with Magellan for services for CalOptima's OneCare and OneCare Connect members, though staff may return with further recommendations on this contract at a future date.

Incorporate MH and ABA Services into CalOptima Operations. In order to integrate MH and ABA services into its operations, CalOptima staff developed a clinical and operational work plan. New infrastructure and resources are necessary to meet this timeframe as well ensure compliance with the Mental Health Parity and Addiction Equity Act, and other regulatory and accreditation requirements. The work plan includes:

1. Develop and implement member transition plan:
    - Send regulatory notices to members regarding change in MBHO;
    - Transition dedicated BH phone number from Magellan to CalOptima;
    - Conduct telephonic outreach to high risk members;
    - Develop reports to monitor open authorizations and member access to care; and
    - Continue to inform community stakeholders, including but not limited to, CalOptima advisory and quality committee members, community-based organizations, and regulatory agencies.
2. Development of a MH and ABA provider network that meets all credentialing and access and availability standards:
    - Establish a MH services provider network to include psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists; and
    - Establish an ABA provider network to include Qualified Autism Service (QAS) providers, including Board Certified Behavioral Analysts (BCBAs), and other licensed professionals in the field; and
    - Establish a standard CalOptima provider fee schedule for MH and ABA services. and
    - Conduct provider meetings to ensure information is disseminated and questions and concerns are addressed.
3. Rely on Magellan's credentialing files in accordance with the National Committee for Quality Assurance (NCQA) guidelines and re-credential the practitioner when they are due.
4. Build infrastructure (staff and systems) to support the following areas:
    - Expand Customer Service to include BH and triage services:
        - Establish specialized customer service unit for BH services;
        - Contract with an external vendor, with the assistance of legal counsel, that has experience with behavioral health services for 24/7/365 referral and after-hours call center support;
    - Ensure adequate resources to process claims timely due to the anticipated increased volume of MH/ABA claims received after the transition period;
    - Incorporate handling of behavior health services provider complaints into existing system;
    - Implement Clinical Operations for BH Utilization Management and Case Management:
        - Perform initial MH screening, determine level of care needs, routine appointment assistance and participation in interdisciplinary care teams;

        - Develop authorization processes for ABA services and psychological testing;
    - Integrate MH and ABA treatment protocols and clinical guidelines into the electronic clinical support system and operations to support decisions;
    - Expand BHI resources for ABA services:
        - Implement process to review prior authorizations for ABA services; and
        - Conduct clinical case management and progress reports;
    - Implement MH/ABA Quality Improvement processes and complete impact analysis of MH/ABA transition on NCQA Accreditation.
5. Hire and train additional clinical and operational staff required to support MH/ABA member needs.
6. Develop and implement reporting and analytic capabilities to meet operational, regulatory and accreditation requirements.

Continued Implementation Efforts. CalOptima staff will continue to identify, develop and/or revise policies and procedures, quality program descriptions, and utilization management program descriptions. Further transition plans as developed as well as policies and programs requiring CalOptima Board approval or ratification will be presented at subsequent meetings.

Fiscal Impact

The fiscal impact for the recommended actions to fund the cost to integrate Medi-Cal covered MH and ABA services internally is projected to be $6.6 million. Management proposes to make a reallocation of budgeted funds approved in the CalOptima FY 2017-18 Operating Budget on June 1, 2017. Funding not to exceed $4.1 million will be reallocated from Medi-Cal administrative costs for Purchased Services to:

- $1.2 million to Medical Management; and
- $2.9 million to Administrative Costs.

In addition, Management requests up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses among the following budget categories: Medical Management, Salaries, Wages and Benefits, Professional Fees, Purchased Services, Printing, Postage and Other Operating Expenses.

Rationale for Recommendation

The CalOptima/Magellan contract will terminate on December 31, 2017. Beginning January 1, 2018, it is critical to ensure continuity of care and access to services for CalOptima members with behavioral health needs. CalOptima staff reviewed multiple options and concluded that, based on the available solutions, the best option is to integrate administration of MH and ABA services into CalOptima operations, with the services continuing to be provided by private sector providers. With the wind down period extending through December 2017, the transition team, consisting of all affected areas' leadership continues to believe that transitioning administration of the behavioral health benefit into CalOptima operations is the best option to minimize any further disruption to members' care. This approach will allow CalOptima to organize care around the needs of our members and work closely with the provider community to provide members with appropriate care.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: Consider Further Actions Related to the Provision of Behavioral Health Services for Medi-Cal Members
2. Board Action dated August 3, 2017, Consider Actions Related to Provision of Behavioral Health Services for Medi-Cal Members

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

8/31/2017 — **Date**

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Consider Further Actions Related to the Provision of Behavioral Health Services for Medi-Cal Members

Board of Directors Meeting

September 7, 2017

Richard Helmer, M.D., Chief Medical Officer

Ladan Khamseh, Chief Operating Officer

Donald Sharps, M.D., Medical Director

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Agenda

- Background of Behavioral Health Services
- Status of Magellan Contract
- Considerations, Recommendations and Rationale
- Transition Planning
- Fiscal Impact
- Recommended Actions

Back to Agenda

Background

- CalOptima is responsible for Behavioral Health (BH) services for Medi-Cal, OneCare and OneCare Connect
- BH services include:
  - Mental Health (MH)
  - Substance Use Disorder (SUD)
  - Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD)
- For Medi-Cal, CalOptima has been responsible for:
  - MH benefit since January 1, 2014
  - ASD Behavioral Health Treatment benefit since September 15, 2014
- Orange County Health Care Agency is responsible for specialty MH services and SUD through Drug Medi-Cal

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Background (Cont.)

- Use of primary care providers (PCPs) for mild behavioral health issues and to support self-management and early identification

- Use of Managed Behavioral Health Organization (MBHO) to provide mild to moderate MH and all ABA services to members:
  - January 2014–December 2016: CHIPA/Beacon (Medi-Cal only)
  - January 2017–Present: Magellan (all populations including OneCare and OneCare Connect)

Status of Magellan Contract

- Contract includes provision allowing reset of reimbursement rates for ABA services based on:
  - Changes to Medi-Cal membership or
  - Penetration rate for ABA services

- On August 3, 2017, the Board authorized an amendment to adjust ABA rates

- Magellan will continue to provide MBHO services through December 31, 2017
  - No current agreement to extend contract beyond December 31, 2017

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Considerations

- Average number of members receiving services
  - MH Services = 6,700 members per month
  - ABA Services = 1,800 members per month
- Previous transition for ABA in past two years
  - Regional Center of Orange County (RCOC) to CalOptima
  - Beacon
  - Magellan
- Contingency strategies considered for transition effective January 1, 2018:
  1. Contract with an MBHO who responded to RFP in 2016
  2. Issue a new RFP
  3. Contract with the previous MBHO
  4. Integrate MH and ABA services into CalOptima operations

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Recommendation

- Integrate administration of MH and ABA services into CalOptima operations with services continuing to be provided by a network of private-sector providers beginning January 1, 2018

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Rationale to Integrate MH and ABA Services

- Utilize existing CalOptima capabilities
  - Network contracting and relations
  - Customer service
  - Behavioral Health Integration department
  - Claims
  - Quality improvement/Credentialing
  - Grievance and appeals
- Minimize disruption to members that would occur with new vendor
- Provide increased opportunities to integrate BH services with medical care in the future

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Transition Planning

- Workgroups have been in place since July 1, 2017

Network Development	Operations
Provider Contracting	Claims
Credentialing	Customer Service
Provider Directory	Grievance and Appeals
Rate Development	Utilization and Care Management
Provider Engagement	Reporting (internal, regulatory, accreditation)

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Transition Planning (Cont.)

- Clinical and operational work plan developed that includes:
  - Member transition plan
  - Provider communication plan
  - MH and ABA provider network development
  - Credentialing process
  - Building infrastructure
  - Staff hiring and training
  - Reporting and analysis capabilities
  - Development or revision of:
    - Policy and procedures
    - Quality program descriptions
    - Utilization management program descriptions

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ABA Providers

- Rates
  - Reference vendor rates for other plans
  - Ensure consistency with State funding for Medi-Cal

- Provider engagement
  - Establish provider information sharing workgroup
  - Continue CalOptima participation in RCOC vendor meetings

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ABA Supervision Model

- Levels of ABA providers
  - Top level: Board Certified Behavioral Analysts (BCBA)
  - Mid level:
    - Current Medi-Cal Guidance
      - Board Certified, non-licensed associate Behavioral Analysts (BCaBA) (minimum bachelor's level)
    - Industry trend
      - Master's level, licensed provider
  - Paraprofessionals: non-licensed individuals with 40 hours of training (minimum high school graduate)

- Ensure appropriate care for children in their homes

Clinical Staffing Requirements

Title	Service Type	Requirements	FTE	Responsibilities
Manager, BH (Clinical)	MH	Licensed MH professionals	1	Oversee the clinical operation of CalOptima BH line
Clinician, BH	MH	Licensed MH professionals	6	Complete telephonic BH assessments; determine BH level of care needs
Member Liaison Specialist (BH)	MH	High School Diploma; BH experience	7	Care management support; assist members in navigating BH system of care and linking to BH services
Manager, BH (BCBA)	ABA	BCBA or BCBA-D	1	Oversee the clinical operation of ABA services
Care Manager (BCBA)	ABA	BCBA	3	Review and process request for authorization of ABA services; utilization management
Member Liaison Specialist (Autism)	ABA	High School Diploma; ABA experience	1	Care management support; assist member in linking to ASD-related services
		Total	**19**	

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BCBA = Board Certified Behavior Analyst

Strategic Clinical Staffing Process

- Sequenced hiring beginning September 2017
  1. Managers
  2. Core staff to support transition
  3. All other staff

- Full staffing by January 1, 2018

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Recruiting and On-Boarding

- Recruiting
  - Positions posted
  - Cultural and linguistic competencies
  - Screening and interviews being conducted
  - Identified potential new hires
  - Offers contingent on Board action

- On-boarding
  - Training specific for BH transition being developed
    - BH coordination
    - Managed care principles
  - CalOptima University for general orientation

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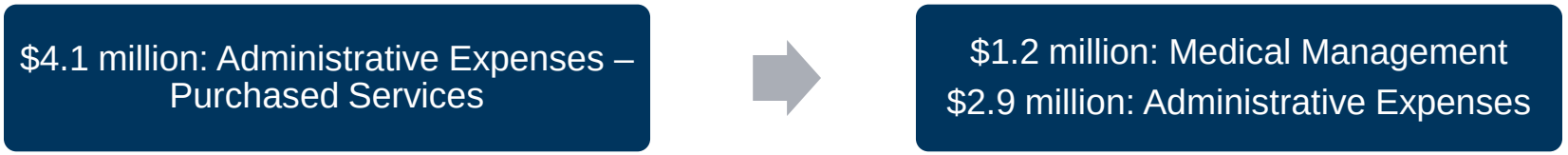
Fiscal Impact

- Estimated cost
  - ➢ $4.1 million: Funded through budget reallocation under FY 2017–18 Medi-Cal Operating Budget



  - ➢ $2.5 million: Unbudgeted expenditures funded from existing reserves for one-time, transition-related contingency funds for Medi-Cal medical and administrative expenses
    - ▪ Distributed among the following budget categories: Medical Management, Salaries, Wages and Benefits, Professional Fees, Purchased Services, Printing, Postage, Other Operating Expenses

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Recommended Actions

1. Authorize the Chief Executive Officer to:
   a. Integrate Medi-Cal covered Behavioral Health (BH), which includes Mental Health (MH) and Applied Behavior Analysis (ABA) services, within CalOptima internal operations, effective January 1, 2018;
   b. Establish a standard CalOptima provider fee schedule for MH and ABA services;
   c. Enter into contracts, with the assistance of legal counsel, with MH and ABA providers; and
   d. Enter into an agreement, with the assistance of legal counsel, for after-hours coverage for CalOptima's behavioral health call center and triage services obtained in accordance with CalOptima's Procurement Policy.

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Recommended Actions (Cont.)

2. Authorize reallocation of budgeted funds not to exceed $4.1 million from Medi-Cal administrative expenses for purchased services approved in the CalOptima FY 2017–18 Operating Budget on June 1, 2017, to Medi-Cal medical and administrative expenses.

3. Authorize unbudgeted expenditures of up to $2.5 million from existing reserves for one-time, transition-related contingency funds for Medi-Cal medical and administrative expenses.

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CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
12. Consider Actions Related to the Provision of Behavioral Health Services for CalOptima Medi-Cal Members

Contact
Ladan Khamseh, Chief Operating Officer, (714) 246-8400
Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400

Recommended Actions
1. Authorize the Chief Executive Officer (CEO) to:
    a. Amend, with the assistance of legal counsel, the Medi-Cal Contract with the existing managed behavioral health organization to transition to a percent of premium basis for compensation of ABA services as part of a 180-day wind down period ending on December 31, 2017~~;~~
    ~~b. Integrate Medi-Cal covered Behavioral Health (BH), which includes Mental Health (MH) and Applied Behavior Analysis (ABA) services, within CalOptima internal operations;~~
    ~~c. Establish a standard CalOptima provider fee schedule for MH and ABA services;~~
    ~~d. Enter into contracts, with the assistance of legal counsel, with MH and ABA providers;~~
    e. ~~Enter into an agreement, with the assistance of legal counsel, for after-hour coverage for CalOptima's behavioral health call center and triage services obtained in accordance with CalOptima's Procurement Policy;~~

Continued to 9/7/2017 Board Meeting

~~2. Authorize reallocation of budgeted funds not to exceed $4.1 million from Medi-Cal administrative expenses for purchased services approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, to Medi-Cal medical and administrative expenses; and~~
~~3. Authorize unbudgeted expenditures of up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses.~~

Background

Medi-Cal MH/ABA Benefits. Behavioral Health services include MH, substance use disorder, and autism spectrum disorder behavioral health treatment (which includes ABA services). Outpatient mild-to-moderate MH services became a covered benefit for Medi-Cal managed care plans as of January 1, 2014. Beginning in September 2014, CalOptima started providing ABA services to Medi-Cal beneficiaries under the age of 21 under the Early and Periodic Screening, Diagnostic, and Treatment benefit. Like many Medi-Cal managed care plans, CalOptima has contracted with Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of behavioral health benefits, including ABA. CalOptima currently contracts with Human Affairs International of California, Inc., dba Magellan Healthcare (Magellan) as its MBHO serving Medi-Cal, OneCare, and OneCare Connect members.

Medi-Cal MH/ABA MBHO. Between January 1, 2014 and December 31, 2016, CalOptima contracted with College Health IPA (CHIPA) and its subcontractor Beacon Health Options as its Medi-Cal

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MBHO. Effective January 1, 2017, the Medi-Cal MH/ABA services were transitioned to Magellan. Magellan was selected as the new MBHO through a 2016 request for proposal (RFP) process that focused on identifying a delivery model that could cover Behavioral Health services for CalOptima's Medi-Cal, OneCare, and OneCare Connect members. On September 1, 2016, the Board authorized a contract with Magellan, effective January 1, 2017, for the full scope Medi-Cal covered mild to moderate mental health and ABA services. Specialty mental health services, including inpatient psychiatric services, remain the responsibility of the Orange County Health Care Agency. In addition, substance use disorder treatment services remain as a carve-out benefit under Drug Medi-Cal. CalOptima provides the coordination of care and service across levels of care (including participating on interdisciplinary care teams), quality initiatives, and oversight. The Board also authorized a separate contract with Magellan for Medicare Behavioral Health services for CalOptima's Medicare Advantage (OneCare) and Cal-MediConnect (OneCare Connect) members.

Magellan Contract. The CalOptima-Magellan contract includes a provision allowing for the reset of reimbursement rates for ABA services based on changes to the Medi-Cal membership or the penetration rate for ABA services. In accordance with the contract, Magellan requested an adjustment to the ABA rates based on the increased Medi-Cal member utilization trends. The parties were unable to reach an agreement when on June 28, 2017, CalOptima received a rescission notice from Magellan asserting the right to rescind the Medi-Cal MBHO Contract effective June 30, 2017, rather than providing the 180-notice of termination provided for in the contract. Subsequently, Magellan entered into a "Settlement Agreement and Order" with the Department of Managed Health Care under which Magellan agreed to provide MBHO as set forth in the Medi-Cal Contract from July 1, 2017 through August 30, 2017.

Discussion

CalOptima staff assessed various options for providing MH and ABA services to Medi-Cal members after the transition date with the intent of keeping the provider network intact to mitigate disruptions to services. The network includes over 530 provider contracts that comprises over 800 MH and 300 ABA providers.

These options included considering contracting with another MBHO who responded to the 2016 RFP, issuing a new RFP, contracting with the previous MBHO, outsourcing certain services, or integrating MH and ABA services into CalOptima operations. After considering these options, staff recommends implementing a model in which coordination and management of MH and ABA services are integrated into CalOptima operations rather than utilizing a vendor/partner for Medi-Cal MH/ABA services as the approach that will best mitigate disruption to Medi-Cal members. At this time, no recommendation is being made on the separate contract with Magellan for services for CalOptima's OneCare and OneCare Connect members, though staff may return with further recommendations on this contract at a future date.

Magellan and CalOptima continued discussions on options for moving forward, with the proposal that Magellan transition to a percent of premium arrangement from CalOptima for the ABA services during a July 1, 2017 through December 31, 2017 transition period. Staff is recommending that your Board authorize integration of administration of Medi-Cal MH and ABA services within CalOptima internal operations and authorize the amendment of the Magellan Contract for the percent of premium

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arrangement from July 1, 2017 through the December 31, 2017 transition end date. While the proposal is to bring administration of this benefit in-house, services will continue to be provided by private sector providers.

Transition Plan to Incorporate MH and ABA Services into CalOptima Operations. In order to transition MH and ABA services into its operations, CalOptima staff developed a clinical and operational work plan. New infrastructure and resources are necessary to meet this timeframe as well ensure compliance with the Mental Health Parity and Addiction Equity Act, and other regulatory and accreditation requirements. The transition plan includes:

1. Development of a MH and ABA provider network that meets all credentialing and access and availability standards:
    - Establish a MH services provider network to include psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists;
    - Establish an ABA provider network to include Qualified Autism Service (QAS) providers, including Board Certified Behavioral Analysts (BCBAs), and other licensed professionals in the field;
2. Rely on Magellan's credentialing files in accordance with the National Committee for Quality Assurance (NCQA) guidelines and re-credential the practitioner when they are due.
3. Build infrastructure (staff and systems) to support the following areas:
    - Expand Customer Service to include BH and triage services:
        - Contract with an external vendor, with the assistance of legal counsel, that has experience with behavioral health services for 24/7/365 referral and after-hours call center support;
    - Ensure adequate resources to process claims timely due to the anticipated increased volume of MH/ABA claims received after the transition period;
    - Incorporate handling of behavior health services provider complaints into existing system;
    - Implement Clinical Operations for BH Utilization Management and Case Management:
        - Perform initial MH screening, determine level of care needs, routine appointment assistance and participation in interdisciplinary care teams;
        - Develop authorization processes for ABA services and psychological testing;
    - Integrate MH and ABA treatment protocols and clinical guidelines into the electronic clinical support system and operations to support decisions;
    - Expand BHI resources for ABA services:
        - Implement process to review prior authorizations for ABA services; and
        - Conduct clinical case management and progress reports;
    - Implement MH/ABA Quality Improvement processes and complete impact analysis of MH/ABA transition on NCQA Accreditation.
4. Hire and train additional clinical and operational staff required to support MH/ABA member needs.
5. Implement reporting and analytic capabilities to meet operational, regulatory and accreditation requirements.

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Continued Implementation Efforts. CalOptima staff will continue to identify and develop or revise policies and procedures, quality program descriptions, and utilization management program descriptions. Further transition plans as developed as well as policies and programs requiring CalOptima Board approval or ratification will be presented at subsequent meetings.

Fiscal Impact

Magellan Medi-Cal Contract Amendment for ABA Services

There is no fiscal impact based on the recommended action to transition to a percent of premium agreement for ABA services for the period of July 1, 2017, through December 31, 2017. Under the CalOptima FY 2017-18 Operating Budget approved on June 1, 2017, Staff budgeted for the increased ABA provider capitation expenses. Staff anticipates the budgeted funds will be sufficient to transition to the proposed payment methodology with Magellan.

BH Services Integration

The fiscal impact for the recommended actions to fund the cost to integrate Medi-Cal covered MH and ABA services internally is projected to be ~~$5.5~~ $6.6 million. Management proposes to make a reallocation of budgeted funds approved in the CalOptima FY 2017-18 Operating Budget on June 1, 2017. Funding not to exceed $4.1 million will be reallocated from Medi-Cal administrative costs for Purchased Services to:

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- $1.2 million to Medical Management; and
- $2.9 million to Administrative Costs.

In addition, Management requests up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses among the following budget categories: Medical Management, Salaries, Wages and Benefits, Professional Fees, Purchased Services, Printing, Postage and Other Operating Expenses.

Rationale for Recommendation

Upon receipt of the notice of rescission from Magellan, it was critical to ensure continuity of care and access to services for CalOptima members with behavioral health needs. CalOptima staff reviewed multiple options and concluded that, based on the available solutions, the best option was to integrate administration of MH and ABA services into CalOptima operations, with the services continuing to be provided by private sector providers. With the proposed wind-down period extending through December 2017, the transition team, consisting of all affected areas' leadership continues to believe that transitioning administration of the behavioral health benefit into CalOptima operations is the best option to minimize any further disruption to members' care. This approach will allow CalOptima to organize care around the needs of our members and work closely with the provider community to provide members with appropriate care.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. PowerPoint Presentation: Consider Actions Related to the Provision of Behavioral Health Services for Medi-Cal Members
2. Board Action dated September 1, 2016, Consider Authorization of Contract with a Managed Behavioral Health Organization (MBHO) Effective January 1, 2017 and Contract with Consultant to Assist with MBHO Contract Implementation; Consider Authorization of Extension of Current Behavioral Health Contracts

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

08/01/2017 — **Date**

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12. Consider Actions Related to the Provision of Behavioral Health Services for Medi-Cal Members

Board of Directors Meeting

August 3, 2017

Richard Helmer, M.D., Chief Medical Officer

Ladan Khamseh, Chief Operating Officer

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Agenda

- Background
- Current State
- Considerations and Recommendations
- Implementation Planning
- Recommended Actions

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Background

- CalOptima is responsible for Behavioral Health (BH) services for Medi-Cal, OneCare, and OneCare Connect
- BH services include:
  - Mental Health (MH)
  - Substance Use Disorder (SUD)
  - Autism Spectrum Disorder or Applied Behavioral Analysis (ABA)
- CalOptima responsible for:
  - Mental health health benefits since January 1, 2014
  - Autism Spectrum Disorder Behavioral Health Treatment benefit beginning September 15, 2014
- Orange County Health Care Agency responsible for specialty MH services and SUD through Drug Medi-Cal

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Background (Cont.)

- Primary care providers and community resources for mild to moderate behavioral health issues and to support self-management and early identification

- Use of Managed Behavioral Health Organizations (MBHO) to provide mild to moderate BH services to members:
  - September 2014 – December 2016: CHIPA/Beacon (Medi-Cal only)
  - January 2017 – Present: Magellan (all populations including OneCare and OneCare Connect)

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Status of Magellan Contract

- Contract includes provision allowing reset of reimbursement rates for ABA services based on:
  - Changes to Medi-Cal membership; or
  - Penetration rate for ABA services
- Magellan requested adjustment to the ABA rates; parties could not reach agreement
- Magellan subsequently agreed to provide MBHO services through December 31, 2017

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Considerations and Recommendations

- Contingency strategies considered for transition effective January 1, 2018:
  1. Contract with an MBHO who responded to RFP in 2016
  2. Issue a new RFP
  3. Contract with the previous MBHO

- Average number of members receiving services:
  - BH Services = 6,700 members per month
  - ABA Services = 1,800 members per month

- Previous transition for ABA in last two years
  - RCOC to CalOptima
  - Beacon
  - Magellan

- Recommendation to mitigate member disruption:
  - Integrate administration of MH and ABA services into CalOptima operations with services continuing to be provided by network of private sector providers

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Transition Implementation Planning

- Clinical and operational workplan developed
- Workgroups have been in place to ensure services during July 1 – December 31, 2017 transition:

Network Development	Operations
Provider Contracting	Claims
Credentialing	Customer Service
Provider Directory	Grievance and Appeals
Rate Development	Utilization & Care Management
	Reporting (internal, regulatory, accreditation)

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Fiscal Impact

- Total estimated cost: Not to exceed $6.6 million
  - $4.1 million: Funded through budget reallocation under FY 2017-18 Medi-Cal Operating Budget

$4.1 million: Administrative Expenses – Purchased Services

$1.2 million: Medical Management
$2.9 million: Administrative Expenses

  - $2.5 million: Unbudgeted expenditures funded from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses
    - Distributed among the following budget categories: Medical Management, Salaries, Wages and Benefits, Professional Fees, Purchased Services, Printing, Postage, Other Operating Expenses

Rationale to Integrate MH and ABA Services

- Utilize existing CalOptima capabilities
  - Network contracting and relations
  - Customer service
  - Behavioral Health Integration Department
  - Claims
  - Quality improvement
  - Grievance and appeals
- Minimize disruption to members that would occur with new vendor
- Provide increased opportunities to integrate BH services with medical care in the future

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Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to:
   a. Amend, with the assistance of legal counsel, the Medi-Cal Contract with the existing managed behavioral health organization to transition to a percent of premium basis for compensation of ABA services as part of a 180-day wind down period ending on December 31, 2017;
   b. Integrate Medi-Cal covered Behavioral Health (BH), which includes Mental Health (MH) and Applied Behavior Analysis (ABA) services, within CalOptima internal operations;
   c. Establish a standard CalOptima provider fee schedule for MH and ABA services;
   d. Enter into contracts, with the assistance of legal counsel, with MH and ABA providers; and
   e. Enter into an agreement, with the assistance of legal counsel, for after-hour coverage for CalOptima's behavioral health call center and triage services obtained in accordance with CalOptima's Procurement Policy;

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Recommended Actions (Cont.)

2. Authorize reallocation of budgeted funds not to exceed $4.1 million from Medi-Cal administrative expenses for purchased services approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, to Medi-Cal medical and administrative expenses; and

3. Authorize unbudgeted expenditures of up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Authorization of Contract with a Managed Behavioral Health Organization (MBHO) Effective January 1, 2017 and Contract with Consultant to Assist with MBHO Contract Implementation; Consider Authorization of Extension of Current Behavioral Health Contracts with College Health Independent Practice Association and Windstone Behavioral Health

Contact

Richard Helmer, Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:
    a. Enter into contract within 30 days with Magellan Health, Inc. to provide behavioral health services for CalOptima Medi-Cal, OneCare, and OneCare Connect members effective January 1, 2017, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.
    b. Contract with a consultant(s) in an amount not to exceed $50,000, to assist with the implementation of the Behavioral Health MBHO contract.
    c. Extend the current contracts with College Health Independent Practice Association (CHIPA) and Windstone Behavioral Health (Windstone) for up to six months, if necessary; and
2. Direct the CEO to return to the Board with further recommendations in the event that a contract is not finalized with Magellan within 30 days.

Background

Like many managed care plans, CalOptima has used Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of behavioral health benefits. Behavioral Health is a covered benefit for CalOptima's Medi-Cal and managed Medicare beneficiaries. CalOptima also provides Behavioral Health Treatment (BHT) services to Medi-Cal beneficiaries under the age of 21 under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. CalOptima currently contracts with CHIPA for the provision of Medi-Cal Managed Care Plan covered behavioral health and BHT services. This contract commenced January 1, 2014, was amended September 15, 2014 to include BHT services, and currently expires on December 31, 2016.

In addition, CalOptima contracts with Windstone to provide behavioral health services for members enrolled in CalOptima's OneCare and OneCare Connect programs. The OneCare contract with Windstone commenced January 1, 2007 and has been extended four times (January 1, 2010, January 1, 2013, January 1, 2014, and January 1, 2015). On May 7, 2015, the CalOptima Board of Directors authorized a contract with Windstone for the OneCare Connect program for the period July 1, 2015 through June 30, 2016, and extension of the Windstone OneCare contract through December 31, 2016. In addition, the CalOptima Board recommended a RFP process for future coverage, to ensure that the best available behavioral health services are obtained for CalOptima members in a most cost effective manner.

All CalOptima behavioral health contracts have been aligned to have the same expiration date. This change was made in part to minimize the possibility of confusion for members new to OneCare

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Connect. On February 4, 2016, the CalOptima Board approved the extension of the OneCare Connect contract through December 31, 2016, thereby aligning all behavioral health contracts termination dates. The Board also authorized the use of a consultant to assist with required activities related to the issuance, scoring and awarding of the RFP for MBHO services.

Discussion

On April 1, 2016, CalOptima contracted with Health Management Associates (HMA) to help conduct a thorough search of potential Behavioral Health vendors and assist in the evaluation process to select the a vendor to provide best practice treatment to members. HMA's scope of work for MBHO RFP included providing assistance in the development of the proposal, creation of the proposal scoring tool, assessment of proposals, and selection of vendor.

On June 1, 2016, CalOptima released the Behavioral Health Request for Proposal (RFP) via BidSync. The CalOptima Procurement Department also contacted identified MBHOs nationwide notifying them about the RFP. Vendors had six weeks to submit their proposals. They also had two opportunities to submit questions to CalOptima about the RFP.

The responses to the RFP were reviewed by an evaluation team consisting of the Executive Director of Clinical Operations, Director of Behavioral Health Services, Behavioral Health Medical Director, and members of the Provider Advisory and Member Advisory Committees. Staff representatives from Claims, Information Services, and Finance scored sections related to their respective technical areas. The evaluation team also met with Subject Matter Experts (SMEs), including Customer Service, Quality Improvement, Grievances and Appeals, Compliance, Case Management, Utilization Management, and Behavioral Health, to discuss the strengths and weaknesses of each proposal.

Selection criteria used for scoring the proposals included:

- Experience in managed care
- Accreditation with the National Committee for Quality Assurance (NCQA)
- Corporate capabilities
- Information processing system
- Financial management
- Proposed staffing and project organization
- Ownership
- Outsourced services
- Provider network management
- Operations
- Utilization management
- Claim processing
- Grievances and Appeals
- Care management
- Cultural competency
- Quality improvement
- Information technology, data management
- Business intelligence

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- Compliance program
- Implementation plan
- Innovation program and services

Based on the evaluation team's scoring, the results for the RFP were as follows:

Vendor	Score
Magellan	4.41
Envolve	4.00
CHIPA	3.54
Optum	3.28
Windstone	2.80

As the table indicates, Magellan finished with the highest score at 4.41 out of 5.

As part of the final review, the evaluation team invited the top two finalists, Magellan and Envolve, to an on-site presentation/interview. In the on-site portion of the evaluation, Magellan finished first with a score of 4.36. Envolve received a score of 2.67 for the on-site portion.

Based on the review of each vendor's capabilities, references, contract requirements and financial costs, the evaluation team is recommending that the Board authorize the CEO to contract with Magellan as the new MBHO. However, in the event that final contract terms cannot be reached within 30 days, staff plans to return to the Board with further recommendations.

Assuming contract terms are reached, the implementation phase will begin as soon as agreement with Magellan has been reached; implementation is calendared to be completed by December 31, 2016. However, if it is identified that additional time is needed for thorough implementation, the team is requesting authorization to extend the existing CHIPA and Windstone proposed to ensure no gap in coverage of behavioral health services. This process includes the winding down of current contracts with CHIPA and Windstone and the transition to the Magellan. Staff also recommends that the Board also authorize a contract with a consultant(s) in an amount not to exceed $50,000 to facilitate this implementation process.

Both CHIPA and Windstone have indicated that they are willing to extend their current contracts in the event that the implementation of the new MBHO contract is not fully completed within the aggressive timeline that is outlined.

Fiscal Impact

Management has included expenses for behavioral health benefits in the CalOptima Fiscal Year (FY) 2016-17 Operating Budget, which is sufficient to fund the projected costs of the new MBHO contract for the period of January 1, 2017, through June 30, 2017. Based on projected enrollment and the proposed rates, Staff estimates the total annual cost of the new MBHO contract will be approximately $41 million.

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In the event CalOptima will need to extend the CHIPA and Windstone contracts, Management will execute an amendment to extend the termination date of the existing contract. No additional expenses will be incurred due to the contract extensions, since there will not be an overlap in dates for when the CHIPA and Windstone contracts expire and the effective date of the new MBHO contract.

The recommended action to authorize the CEO to contract with a consultant to assist with the implementation of the Behavioral Health MBHO contract is unbudgeted and will not exceed $50,000 through June 30, 2017. An allocation of $50,000 from existing reserves will fund this action.

Rationale for Recommendation

CalOptima staff believes contracting with the selected MBHO will allow CalOptima to continue to provide a comprehensive provider network and Behavioral Health and Autism Spectrum Disorder services for CalOptima's Medi-Cal and Duals programs. The evaluation team reviewed qualified MBHO responses and identified the candidate believed to best meet CalOptima's needs for integration of care, regulatory compliance, operational efficiency, administrative simplification, best practices, as well as overall reasonableness of price. The recommended MBHO is expected to be able to provide all delegated functions related to Behavioral Health Benefits including, but not limited to, customer service, care management, utilization management, credentialing, quality improvement, claims processing and payment, and provider dispute resolution. Moreover, the recommended MBHO will help CalOptima organize care around the needs of our members to achieve efficient and effective assessment, diagnosis, care planning, strength based and person centered treatment implementation, support services and outcomes evaluation.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Actions referenced:
    a. Board Action dated December 5, 2013, Contract with College Health Independent Practice Association for the Provision of Medi-Cal Outpatient Mental Health Services Beginning on January 1, 2014
    b. Board Actions dated October 2, 2014:
        i. Amendments to the Primary Agreement between DHCS and CalOptima to Implement Behavioral Health Therapy Benefit
        ii. Amend CalOptima's Contract with College Health Independent Association to Include Behavioral Health Therapy Services to meet DHCS Requirements
    c. Board Action dated May 7, 2015 Authorizing Contract for Behavioral Health Services with Windstone Behavioral Health
    d. Board Action dated February 4, 2016 Authorizing the Extension of the Contract with Windstone Behavioral Health for Behavioral Health Services
2. Behavioral Health Services PowerPoint Presentation

/s/ Michael Schrader — *8/25/2016*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

V. F. Authorize the Chief Executive Officer (CEO) to Contract with College Health Independent Practice Association (CHIPA) for the Provision of Medi-Cal Outpatient Mental Health Services Beginning on January 1, 2014

Contact

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

Recommended Action

Authorize the CEO, with the assistance of legal counsel, to enter into a contract with CHIPA for the provision of Medi-Cal outpatient mental health services, as defined by the Department of Health Care Services (DHCS), effective January 1, 2014 for a one year term with two one year extension options, exercisable at CalOptima's discretion.

Background

At its September 5, 2013 meeting, the CalOptima Board of Directors authorized the CEO to contract with Beacon Health Strategies, LLC (Beacon) to provide outpatient mental health services effective January 1, 2014 based legislative changes requiring Medi-Cal managed care plans to provide these services. Excluded from this arrangement are benefits provided by county mental health plans under the Specialty Mental Health Services Waiver, which CalOptima administers under a separate contract with the Orange County Health Care Agency (OCHCA), and also contracts with Beacon for the provision of administrative services organization (ASO) services under the CalOptima contract with the OCHCA. Separately, CHIPA has a Master Service Agreement with Beacon.

Discussion

As CalOptima prepares to provide all Medi-Cal members with mental health benefits beginning on January 1, 2014, it has been determined that Beacon is neither Knox-Keene licensed in CalOptima's service area nor a professional corporation. Consequently, Beacon cannot be fully delegated for the medical management of the program. Instead, under CalOptima's National Committee Quality Improvement (NCQA) accreditation for the Medi-Cal program, the contract for the medical management of the mental health program must be directly with the delegated entity performing the utilization management for the program. Although Beacon can function as the Management Services Organization (MSO), it cannot perform the full delegation required by CalOptima. As a result, staff recommends that CalOptima instead contract directly with CHIPA, which in turn, has an existing management services agreement with Beacon.

Operational

By contracting with CHIPA, CalOptima will be positioned to continue to leverage Beacon's expertise, experience with the Medi-Cal program, and substantial provider network, as well as meet the NCQA delegation requirements. Additionally, based on CalOptima's experience with Beacon staff co-located at CalOptima's facility for the last three years, CHIPA and Beacon are integrated into CalOptima's operational processes. This is particularly important given the aggressive timeline for implementation of the new benefit.

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Member Experience
With the implementation of the new benefit, CalOptima's goal is to ensure that members' continue to have a seamless experience of care. CalOptima's relationship with Beacon through CHIPA will allow staff to leverage the existing services and processes that Beacon has in place.

In summary, staff proposes contracting with CHIPA for the provision of the new Medi-Cal managed care mental health benefit. Having a contract in place with CHIPA prior to the implementation date of the new benefit will allow CalOptima staff to respond quickly to the requirements associated with implementing this mandatory new benefit. Staff believes that this recommendation will result in optimal member care and allow CalOptima to leverage existing resources and operational processes to the fullest extent.

Fiscal Impact
The recommended action to provide Medi-Cal mental health services will result in revenue neutrality for CalOptima. Management believes that DHCS will apply an adjustment to Medi-Cal capitation rates through a forthcoming contract amendment in an amount equivalent to the benefit expense plus an administrative load. Management will operate the program within the confines of this revenue allocation.

Rationale for Recommendation
A contract with CHIPA for the delivery of this new Medi-Cal mental health benefit will allow CalOptima to maintain the NCQA standards for delegation and leverage existing Beacon resources and operational processes to the fullest extent. Additionally, CalOptima must be prepared to provide this benefit to all Medi-Cal members beginning January 1, 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachment
None

/s/ Michael Schrader — *11/27/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. A. Authorize and Direct the Chairman of the Board of Directors to Execute Amendments to the Primary Agreement between the California Department of Health Care Services (DHCS) and CalOptima to Implement the Behavioral Health Therapy (BHT) Benefit

Contact
Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Action
Authorize and direct the Chairman of the Board of Directors to execute Amendments to the Primary Agreement between the California DHCS and CalOptima (Primary Agreement) to implement the Behavioral Health Therapy (BHT) Benefit.

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 agreement with DHCS. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion
On August 29, 2014, DHCS notified Medi-Cal Managed Care Plans (Plans) that effective September 15, 2014, Plans' responsibility for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services will extend to coverage of Behavioral Health Therapy (BHT). Through the same notification, DHCS provided draft interim policy guidance regarding BHT services to include Applied Behavioral Analysis (ABA).

On September 15, 2014, DHCS released the final interim policy guidance pertaining to BHT services in Medi-Cal managed care for children and adolescents 0 to 21 years of age diagnosed with Autism Spectrum Disorder (ASD). The final interim guidance includes information regarding recipient criteria, covered services and limitations.

DHCS is beginning the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with health plans and stakeholders. DHCS committed to Plans to develop rates, which will be retroactive to September 15, 2014. DHCS will also engage stakeholders to further define eligibility criteria, provider participation criteria, utilization controls, and the delivery system for ABA services.

At this time, CalOptima staff requests your approval of amendments necessary with DHCS to implement the BHT benefit, subject to the terms being consistent with the requirements of the benefit and the rates being satisfactory to provide the services. While the State has not yet provided any amendments to CalOptima for execution, management understands that the State will present them in

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the near future and require prompt execution. There is a separate staff report and recommended action for your Board's consideration related to the administration of the BHT benefit by College Health Independent Practice Association (CHIPA)

Fiscal Impact
At this time, the fiscal impact of the BHT benefit is unknown.

Rationale for Recommendation
The approval of amendments will make language changes consistent with EPSDT requirements and ensure CalOptima will receive funding for the benefit.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to Primary Agreement with DHCS

/s/ Michael Schrader — *9/26/2014*
Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM VII. A.

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
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

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Amendments to Primary Agreement	Board Approval
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, 2014 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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. B. Ratify Amendment of CalOptima's Contract with College Health Independent Practice Association (CHIPA) to Include Behavioral Health Therapy (BHT) Services, Including Applied Behavioral Analysis (ABA) Services, to Meet Department of Health Care Services (DHCS) Requirements; Authorize the Development of Policies and Procedures as Necessary to Implement the BHT Benefit

Contact

Donald Sharps, M.D., Medical Director, (714) 246-8400

Recommended Actions

1. Ratify amendment of CalOptima's contract with College Health Independent Practice Association (CHIPA) to implement the Behavioral Health Therapy (BHT), including ABA services, effective September 15, 2014 for Medi-Cal beneficiaries aged 0 to 21 years diagnosed with Autism Spectrum Disorder (ASD); and
2. Authorize the Chief Executive Officer (CEO) to develop and implement required policies and procedures as required to implement the BHT benefit as required by the Department of Health Care Services (DHCS).

Background

Behavioral Health Treatment Benefit for Autism
On August 29, 2014, the Department of Health Care Services (DHCS) released a draft All Plan Letter (APL) to provide interim policy guidance for Medi-Cal Managed Care Plans' (Plans) coverage of Behavioral Health Treatment (BHT) for children diagnosed with Autism Spectrum Disorder (ASD).

CalOptima was informed at that time of DHCS's intent to provide BHT services as a covered Medi-Cal benefit for individuals 0 to 21 years of age with ASD to the extent required by the federal government under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. DHCS is currently seeking federal approval to provide BHT as it is defined by Section 1374.73 of the California Health and Safety Code. DHCS has begun the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with health plans and stakeholders. DHCS released a subsequent APL on this topic dated September 15, 2014. Based on this guidance:

- Effective September 15, 2014, Plans' responsibility for the provision of EPSDT services for beneficiaries 0 to 21 years of age were further defined to include medically necessary BHT services such as ABA and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD. Plans (including CalOptima) are obligated to ensure that appropriate EPSDT services are initiated in accordance with timely access standards; and

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- Continuity of Care under the following circumstances:
  - Plan members 0 to 21 years diagnosed with ASD who, as of September 14, 2014 were receiving BHT services including ABA services through a Regional Center will continue to receive these services through the Regional Center until such time that the department and the Department of Developmental Services develop a plan for transition.
  - For a Plan's Medi-Cal members receiving BHT services outside of the Plan's network for Medi-Cal services, the Plan is obligated to ensure continuity of care for up to 12 months in accordance with existing contract requirements.
    - DHCS also detailed the requirements for out-of-network providers
  - Plans shall not discontinue BHT services during a continuity of care evaluation.

- Rates:
  - Per the APL, DHCS has committed to working with Plans to develop capitation rates for the costs associated with the provision of ABA services. Any rate adjustments will be retroactively applied to September 15, 2014.
  - On and after September 15, 2014, beneficiaries must receive ABA services from the Plan unless they are receiving their ABA services from a Regional Center.

- DHCS has also provided:
  - Recipient Criteria For ABA-Based Therapy Services
  - Defined Covered Services under Welfare & Institutions Code section 14059.5.
  - Limitations for services to include discontinuation when treatment goals and objectives are achieved or are no longer appropriate

CalOptima's Behavoral Health Intergration unit has been working with our contracted Medi-Cal Behavioral Health Vendor CHIPA/Beacon to gain a better understanding of the population of CalOptima members who may ultimately access ABA services. CalOptima has approximately 314,000 members age 18 and under, with an estimated incidence of autism at approximately 1.0 percent, or roughly 3,140 children. From that group, it is estimated, based on experience with similar populations they service, that approximately 20 percent may use ABA services, or 628 members. Beacon projects approximately half of those children will continue to receive ABA services through the Regional Center of Orange County, which is allowed until the state develops its transition plan. It is anticipated that CalOptima will serve approximately 314 members under this new benefit. However these figures may vary depending on a number of factors, including whether members' parent or guardian wish to continue receiving these services through the Regional Center.

Discussion

CalOptima is currently contracted with CHIPA for the medical management of the Medi-Cal mental health program, which in turn, has an existing management services agreement with Beacon.

Operational
By amending the current contract with CHIPA, CalOptima will be positioned to continue to leverage Beacon's experience with the mental health benefit included in the Medi-Cal program and also meet both DHCS regulatory and National Committee for Quality Assurance (NCQA) accreditation requirements.

Member Experience
With the implementation of the new benefit, CalOptima's goal is to ensure that members continue to have a seamless experience of care. CalOptima's relationship with Beacon through CHIPA allows staff to leverage the existing services and processes that Beacon currently has in place.

Clinical Expertise
Autism Service Group (ASG) has been fully integrated with CHIPA/Beacon for the last four years. Beacon ASG administers autism benefits on behalf of a number of health plans. Services that Beacon ASG provides include Network Management, ASD diagnosis validation, a comprehensive assessment and intake process, Care Management, Claims, and Reporting.
CalOptima and other Plans can expect that DHCS:

- Will require them to undergo a readiness review with DHCS. In the coming weeks, both the DHCS and the Department of Managed Health Care (DMHC) will issue a readiness review checklist. This checklist is expected to include submission timelines which will mirror each other when both Departments are collecting the same information. Both Departments are also working to draft template Evidence of Coverage (EOC) language. This language is expected to be shared with Plans in the near future.

- Will update APL 13-023, *Continuity of Care for Medi-Cal Beneficiaries who Transition from Fee-For-Service Medi-Cal into Medi-Cal Managed Care*, to include the new benefit. These new requirements are expected to include:
    - New noticing requirements when continuity of care: 1) are approved, and 2) approvals are 30 days from ending;
    - Retroactive coverage in certain situations;
    - Utilization management requirements for qualified providers; and
    - Timelines for approving requests when more immediate attention is needed and when there is a risk of harm.

In summary, management requests ratification of an amendment to the current CalOptima-CHIPA contract to include the provision of BHT services related to ASD as required by DHCS.

Fiscal Impact
As proposed, Beacon will be paid via capitation, at a rate of $0.14 per member per month (PMPM) for the period prior to the Regional Center of Orange County transition (September 15, 2014), and $0.25 PMPM for the period after the transition. Based on the projected total costs of ABA services, these rates result in administrative loads of 7.1% and 6.4% respectively for Beacon. As indicated, based on

APL 14-011, management anticipates that the DHCS will work with Plans including CalOptima to ensure that the new capitation rates are sufficient to cover the cost of providing this enhanced benefit.

Rationale for recommendation
The proposed changes are intended to ensure that, within the parameters delineated by the DHCS, CalOptima Medi-Cal beneficiaries have access to this newly added Medi-Cal mental health benefit.

Concurrence
Gary Crockett, Chief Counsel

Attachment
DHCS All Plan Letter 14-011

/s/ Michael Schrader — *9/26/2014*
Authorized Signature — **Date**

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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: September 15, 2014

All Plan Letter 14-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: INTERIM POLICY FOR THE PROVISION OF BEHAVIORAL HEALTH TREATMENT COVERAGE FOR CHILDREN DIAGNOSED WITH AUTISM SPECTRUM DISORDER

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with interim policy guidance for providing Behavioral Health Therapy (BHT) services to Medi-Cal children and adolescent beneficiaries 0 to 21 years of age diagnosed with Autism Spectrum Disorder (ASD).

BACKGROUND:
ASD is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called ASD[1]. Currently, the Centers for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD.

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance regarding the coverage of BHT services pursuant to section 1905(a)(4)(B) of the Social Security Act (the Act) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to provide coverage to individuals eligible for the EPSDT benefit for any Medicaid covered service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to ensure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and

[1] See Diagnostic and Statistical Manual (DSM) V.

Medi-Cal Managed Care Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Telephone (916) 449-5000 Fax (916) 449-5005
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treated as early as possible. When medically necessary, States may not impose limits on EPSDT services and must cover services listed in section 1905(a) of the Act regardless of whether or not they have been approved under a State Plan Amendment.

All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. When a screening examination indicates the need for further evaluation of a child's health, the child must be appropriately referred for medically necessary diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to ensure children receive the health care they need, when they need it.

The Department of Health Care Services (DHCS) intends to include BHT services, including Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD, as a covered Medi-Cal benefit for individuals 0 to 21 years of age with ASD to the extent required by the federal government. DHCS will seek federal approval to provide BHT as it is defined by Section 1374.73 of the Health and Safety (H&S) Code.

Pursuant to Section 14132.56 of the Welfare & Institutions Code (WIC), DHCS is beginning the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT as defined by H&S code section 1374.73, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with stakeholders. In consultation with stakeholders, DHCS will further develop and define eligibility criteria, provider participation criteria, utilization controls, and the delivery system for BHT services, subject to the limitations allowed under federal law, and provide final policy guidance to MCPs upon federal approval.

PROGRAM DESCRIPTION AND PURPOSE:
BHT means professional services and treatment programs, including but not limited to ABA and other evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services are services based on reliable evidence and are not experimental.

INTERIM POLICY:
In accordance with existing contracts, MCPs are responsible for the provision of EPSDT services for members 0 to 21 years of age, including those who have special health care needs. MCPs shall: (1) inform members that EPSDT services are available for beneficiaries 0 to 21 years of age, (2) provide comprehensive screening and prevention

services, (including, but not limited to, a health and developmental history, a comprehensive physical examination, appropriate immunizations, lab tests, lead toxicity screening, etc.), and (3) provide diagnosis and treatment for all medically necessary services, including but not limited to, BHT.

Effective September 15, 2014, the MCP responsibility for the provision of EPSDT services for beneficiaries 0 to 21 years of age includes medically necessary BHT services such as ABA and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD. MCPs shall ensure that appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the MCP's contracts.

CONTINUITY OF CARE:
MCP beneficiaries 0 to 21 years diagnosed with ASD who are receiving BHT services through a Regional Center on September 14, 2014, will automatically continue to receive all BHT services through the Regional Center until such time that DHCS and the Department of Developmental Services (DDS) develop a plan for transition. Until DHCS and DDS develop a plan for transition and communicate this transition plan to Regional Centers and to MCPs (through a forthcoming APL), Regional Centers will continue to provide BHT services for Medi-Cal beneficiaries and reimburse providers for BHT services provided in accordance with existing federal approvals, unless the parent or guardian requests that the MCP provide BHT services to the beneficiary prior to the development and/or implementation of the transition plan. Beneficiaries presenting for BHT services at a Regional Center on or after September 15, 2014, should be referred to the MCP for services.

For Medi-Cal beneficiaries receiving BHT services outside of a Regional Center or the MCPs' network, upon parental or guardian request, the MCPs shall ensure continuity of care for up to 12 months in accordance with existing contract requirements and All Plan Letter (APL) 13-023, unless the parent or guardian requests that the MCP change the service provider to an MCP BHT in-network provider prior to the end of the 12 month period.

BHT services will not be discontinued during a continuity of care evaluation. Pursuant to Health & Safety Code section 1373.96, BHT services must continue until MCPs have established a treatment plan.

An MCP shall offer continuity of care with an out-of-network provider to beneficiaries if all of the following circumstances exist:

- The beneficiary has an existing relationship with a qualified autism service provider. An existing relationship means a beneficiary has seen an out-of-network provider at least twice during the 12 months prior to September 15, 2014;

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- The provider is willing to accept payment from the MCP based on the current Medi-Cal fee schedule; and

- The MCP does not have any documented quality of care concerns that would cause it to exclude the provider from its network.

HEALTH PLAN READINESS:
DHCS and the Department of Managed Health Care (DMHC) will coordinate efforts to conduct readiness reviews of MCPs for purposes of ensuring that MCPs are providing timely medically necessary BHT services. DHCS and DMHC will engage in joint decision making processes when considering the content of any licensing filing submitted to either department. The departments will work together to issue template language to MCPs, as needed.

Guidance pertaining to MCPs' readiness review requirements will be provided to MCPs separate from this APL.

DELEGATION OVERSIGHT:
MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements, as well as DHCS guidance, including APLs.

REIMBURSEMENT:
DHCS will engage in discussions with the MCPs in order to develop capitation rates for the costs associated with the provision of BHT services as soon as possible. Any rate adjustments for BHT services will be retroactively applied to September 15, 2014, subject to federal approval.

To the extent Medi-Cal beneficiaries received BHT services from licensed providers between July 7, 2014, and up to and including September 14, 2014, and incurred out-of-pocket expenditures for such services, these expenditures shall be submitted to the Fiscal Intermediary for reimbursement of expenditures through the existing *Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan)* process (http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_Conlan.aspx). On and after September 15, 2014, Medi-Cal beneficiaries that are not receiving BHT services from a Regional Center or an out-of-network provider must receive all BHT services from a MCP.

CRITERIA FOR BHT SERVICES:
In order to be eligible for BHT services, a Medi-Cal beneficiary must meet all of the following coverage criteria. The recipient must:

1. Be 0 to 21 years of age and have a diagnosis of ASD;
2. Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to, aggression, self-injury, elopement, and/or social interaction, independent living, play and/or communication skills, etc.);

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3. Be medically stable and without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID);
4. Have a comprehensive diagnostic evaluation[2] that indicates evidence-based BHT services are medically necessary and recognized as therapeutically appropriate; and
5. Have a prescription for BHT services ordered by a licensed physician or surgeon or developed by a licensed psychologist.

COVERED SERVICES AND LIMITATIONS:

Medi-Cal covered BHT services must be:

1. Medically necessary as defined by Welfare & Institutions Code Section 14132(v).
2. Prior authorized by the MCP or its designee; and
3. Delivered in accordance with the beneficiary's MCP approved treatment plan.

Services must be provided and supervised under an MCP approved treatment plan developed by a contracted and MCP-credentialed "qualified autism service provider" as defined by Health & Safety Code Section 1374.73(c)(3). Treatment services may be administered by one of the following:

1. A qualified autism service provider as defined by H&S Code section 1374.73(c)(3).
2. A qualified autism service professional as defined by H&S Code section 1374.73(c)(4) who is supervised and employed by the qualified autism services provider.
3. A qualified autism service paraprofessional as defined by H&S Code section 1374.73(c)(5) who is supervised and employed by a qualified autism service provider.

BHT services must be based upon a treatment plan that is reviewed no less than every six months by a qualified autism service provider and prior authorized by the MCP for a time period not to exceed 180 days. Services provided without prior authorization shall not be considered for payment or reimbursement except in the case of retroactive Medi-Cal eligibility.

BHT services shall be rendered in accordance with the beneficiary's treatment plan. The treatment plan shall:

1. Be person-centered and based upon individualized goals over a specific timeline;
2. Be developed by a qualified autism service provider for the specific beneficiary being treated;
3. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors;

[2] MCPs shall obtain a diagnostic evaluation of no more than four hours in duration that includes:

- A clinical history with informed parent/guardian, inclusive of developmental and psychosocial history;
- Direct observation;
- Review of available records; and
- Standardized measures including ASD core features, general psychopathology, cognitive abilities, and adaptive functioning using published instruments administered by qualified members of a diagnostic team.

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4. Identify long, intermediate, and short-term goals and objectives that are specific, behaviorally defined, measurable, and based upon clinical observation;
5. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives;
6. Utilize evidence-based practices with demonstrated clinical efficacy in treating ASD, and are tailored to the beneficiary;
7. Ensure that interventions are consistent with evidenced-based BHT techniques.
8. Clearly identify the service type, number of hours of direct service and supervision, and parent or guardian participation needed to achieve the plan's goals and objectives, the frequency at which the beneficiary's progress is reported, and identifies the individual providers responsible for delivering the services;
9. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
10. Include parent/caregiver training, support, and participation.

BHT Service Limitations:

1. Services must give consideration to the child's age, school attendance requirements, and other daily activities as documented in the treatment plan.
2. Services must be delivered in a home or community-based settings, including clinics.
3. BHT services shall be discontinued when the treatment goals and objectives are achieved or are no longer medically necessary.
4. MCPs will comply with current contract requirements relating to coordination of care with Local Education Agencies to ensure the delivery of medically necessary BHT services.

The following services do not meet medical necessity criteria, nor qualify as Medi-Cal covered BHT services for reimbursement:

1. Therapy services rendered when continued clinical benefit is not expected;
2. Services that are primarily respite, daycare or educational in nature and are used to reimburse a parent for participating in the treatment program;
3. Treatment whose purpose is vocationally or recreationally-based;
4. Custodial care
   a. for purposes of BHT services, custodial care:
      i. shall be defined as care that is provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating, and maintaining personal hygiene and safety;
      ii. is provided primarily for maintaining the recipient's or anyone else's safety; and
      iii. could be provided by persons without professional skills or training.
5. Services, supplies, or procedures performed in a non-conventional setting including, but not limited to:
   a. resorts;
   b. spas; and
   c. camps.

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6. Services rendered by a parent, legal guardian, or legally responsible person.

For questions about this APL, contact your Medi-Cal Managed Care Division Contract Manager.

Sincerely,

Original Signed by Sarah C. Brooks

Sarah C. Brooks
Program Monitoring and Medical Policy Branch Chief
Medi-Cal Managed Care Division
Department of Health Care Services

Attachments

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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

What to Expect if You Suspect or You Have Been Told Your Child has Autism Spectrum Disorder

If you have a concern about how your child is communicating, interacting or behaving, or your child has been diagnosed with autism spectrum disorder (ASD) but you have been unable to access services to treat your child, you are likely wondering what to expect now that Behavioral Health Treatment services to treat children with ASD are available in Medi-Cal.

The following guidance is provided to share information about obtaining an evaluation of your child's development and treatment options, if needed, and the approximate amount of time it will take to obtain evaluations and medically necessary treatment.

1. If you have concerns about your child's development or your child has been diagnosed with ASD, call your Health Plan's Call Center and/or make an appointment to see your child's doctor. Your child's doctor should offer you an appointment within 10 business days. The evaluation and approval processes for your child to receive Behavioral Health Treatment services could take approximately 60 to 90 days to complete.

2. At the appointment with your child's doctor, share your concerns about your child, noting how your child is different from other children the same age, or provide any documents you may have from a health care provider that state your child has been diagnosed with autism spectrum disorder.

3. Your child's doctor will listen to your concerns, review documents that you share, examine your child, and may conduct a developmental screening. The doctor may ask you questions or talk or play with your child during the examination to see how your child learns, speaks, behaves, and moves. This screening provides useful information to identify if your child is developing differently from other children.

4. As a result of this visit with the doctor, your child may be referred to a specialist who will meet with you and your child, conduct further tests/exams of your child, and then prepare a report. The specialist should offer you an appointment within 15 business days after your appointment with your child's doctor.

5. The specialist will submit his/her report to your child's Health Plan for review and approval of medically necessary services, if deemed necessary.

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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

6. Your child's Health Plan will notify you of its determination whether or not to provide Behavioral Health Treatment services to your child in accordance with the recommendations of the specialist.

7. If the Health Plan determines that Behavioral Health Treatment services are medically necessary, your child will be referred to a qualified autism service provider who will meet with you and your child and develop a treatment plan. The qualified autism service provider should offer to meet with you within 15 business days after your Health Plan makes its determination.

8. The proposed treatment plan will be submitted by the qualified autism service provider to the Health Plan and reviewed by your Health Plan to determine whether or not the Behavioral Health Treatment services recommended by the qualified autism service provider are medically necessary.

9. Your child's Health Plan will notify you of its determination whether or not to provide Behavioral Health Treatment services to your child in accordance with the treatment plan developed by the qualified autism service provider.

10. If the Health Plan determines that Behavioral Health Treatment services recommended by the qualified autism service provider are medically necessary, your child will be referred back to the qualified autism service provider who will meet with you and your child in your home or another community setting, such as a community clinic, to describe the treatment plan and specific services your child will receive. The qualified autism provider should offer you an appointment within 15 days after your Health Plan makes its determination.

11. You have the right to make complaints about your child's covered services or care. This includes the right to:

    a) File a complaint or grievance or appeal certain decisions made by the Health Plan or health plan provider. For more information on filing a complaint, grievance, or appeal, contact your Health Plan.

    b) Ask for an Independent Medical Review (IMR) of the medical necessity of Medi-Cal Services or terms that are medical in nature from the California Department of Managed Health Care (DMHC). For more information on asking for an IMR, contact DMHC's Help Center at 1-888-466-2219 or (TDD) 1-877-688-9891 or online at http://www.dmhc.ca.gov/FileaComplaint/ConsumerIndependentMedicalReviewComplaint.aspx

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

TOBY DOUGLAS
DIRECTOR

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GOVERNOR

c) Ask for a State Fair Hearing (SFH) from the California Department of Social Services (DSS). You can request a SFH over the phone by contacting DSS at 1-800-952-5253 or (TDD) 1-800-952-8349, by faxing DSS at 916-651-5210 or 916-651-2789, or by sending a letter to DSS. Additional information on the SFH process can be accessed at: http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx

12. The qualified autism service provider will meet with you and your child and describe the behavioral health treatment service type, the number of hours of direct service and the supervision of the service provider, parent or guardian participation needed, the frequency of reporting progress, and identify the individual providers responsible for delivering services to your child. Services will be scheduled at the location and in the frequency approved by the Health Plan.

13. The qualified autism service provider will provide a description of care coordination involving parents, guardians or caregivers, school, state disability programs, and others. The provider will also describe parent, guardian or caregiver training, support and participation that will be required.

14. The effectiveness of Behavioral Health Treatment is dramatically improved when parents or guardians receive training and are actively participating in their child's treatment. Your participation will ensure the best long term outcomes from the treatments your child is receiving.

15. If you have any questions or concerns about obtaining services for your child at any point in the process, call your Health Plan's Call Center or your child's doctor for assistance.

16. If you are concerned about what you can do when your child is not receiving services, the federal government and the Association for Children and Families has put together a guide to help parents facilitate development every day. This guide can be found at www.acf.hhs.gov/ecd/ASD. Themes include:

    a. Engaging your child in play through joint attention
    b. Using your child's interests in activities
    c. Using a shared agenda in daily routines
    d. Using visual cues
    e. Sharing objects and books
    f. Teaching your children to play with each other
    g. Using predictable routines and predictable spaces for your child.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: July 7, 2014

FROM: Cindy Mann, Director
Center for Medicaid and CHIP Services

SUBJECT: **Clarification of Medicaid Coverage of Services to Children with Autism**

In response to increased interest and activity with respect to services available to children with autism spectrum disorder (ASD), CMS is providing information on approaches available under the federal Medicaid program for providing services to eligible individuals with ASD.

Background

Autism spectrum disorder is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called autism spectrum disorder. Currently, the Center for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD. [1]

Treatments for children with ASD can improve physical and mental development. Generally these treatments can be categorized in four categories: 1) behavioral and communication approaches; 2) dietary approaches; 3) medications; and 4) complementary and alternative medicine. [2] While much of the current national discussion focuses on one particular treatment modality called Applied Behavioral Analysis (ABA), there are other recognized and emerging treatment modalities for children with ASD, including those described in the ASD Services, Final Report on Environmental Scan (see link below)[3]. This bulletin provides information related to services available to individuals with ASD through the federal Medicaid program.

The federal Medicaid program may reimburse for services to address ASD through a variety of authorities. Services can be reimbursed through section 1905(a) of the Social Security Act (the Act), section 1915(i) state plan Home and Community-Based Services, section 1915(c) Home

[1] http://www.cdc.gov/ncbddd/autism/facts.html
[2] http://www.cdc.gov/ncbddd/autism/treatment.html
[3] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/Autism-Spectrum-Disorders.pdf

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and Community-Based Services (HCBS) waiver programs and section 1115 research and demonstration programs.

State Plan Authorities

Under the Medicaid state plan, services to address ASD may be covered under several different section 1905(a) benefit categories. Those categories include: section 1905(a)(6) - services of other licensed practitioners; section 1905(a)(13)(c) - preventive services; and section 1905(a)(10) - therapy services. States electing these services may need to update the Medicaid state plan in order to ensure federal financial participation (FFP) is available for expenditures for these services. In addition, for children, as discussed below, states must cover services that could otherwise be covered at state option under these categories consistent with the provisions at 1905(a)(4)(B) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Below is information on these coverage categories for services to address ASD. Under these section 1905(a) benefit categories all other state Medicaid plan requirements such state-wideness and comparability must also be met.

Other Licensed Practitioner Services

Other Licensed Practitioner services (OLP) services, defined at 42 CFR 440.60, are "medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law." If a state licenses practitioners who furnish services to address ASD, the state may elect to cover those providers under this section of their state plan even if the providers are not covered under other sections of the plan (e.g., physical therapist, occupational therapist, etc.). A state would need to submit a state plan amendment (SPA) to add the new licensed provider to their Medicaid plan. The SPA must describe the provider's qualifications and include a reimbursement methodology for paying the provider.

In addition, services that are furnished by non-licensed practitioners under the supervision of a licensed practitioner could be covered under the OLP benefit if the criteria below are met:

- Services are furnished directly by non-licensed practitioners who work under the supervision of the licensed practitioners;
- The licensed provider is able to furnish the service being provided;
- The state's Scope of Practice Act for the licensed practitioners specifically allows the licensed practitioners to supervise the non-licensed practitioners who furnish the service;
- The state's Scope of Practice Act also requires the licensed practitioners to assume professional responsibility for the patient and the service furnished by the unlicensed practitioner under their supervision; and
- The licensed practitioners bill for the service;

Preventive Services

Preventive Services, defined at 42 CFR 440.130(c) are "services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to—

(1) Prevent disease, disability, and other health conditions or their progression;
(2) Prolong life; and
(3) Promote physical and mental health and efficiency"

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A regulatory change that took effect January 1, 2014, permits coverage of preventive services furnished by non-licensed practitioners who meet the qualifications set by the state, to furnish services under this state plan benefit as long at the services are recommended by a physician or other licensed practitioner. Under the preventive services benefit, in the state plan, the state must 1) list the services to be provided to ensure that services meet the definition of preventive services as stated in section 4385 of the State Medicaid Manual (including the requirement for the service to involve direct patient care); 2) identify the type(s) of non-licensed practitioners who may furnish the services; and 3) include a summary of the state's provider qualifications that make these practitioners qualified to furnish the services, including any required education, training, experience, credentialing, supervision, oversight and/ or registration.

Therapy Services

Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit at 42 CFR 440.110. Physical and occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law and provided to a beneficiary by or under the direction of a qualified therapist. Services for individuals with speech, hearing and language disorders mean diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

States would need to include an assurance in the state plan that the state furnishes the therapy in accordance with 42 CFR 440.110. States would also need to describe the supervisory arrangements if a practitioner is furnishing the therapy under the direction of a qualified therapist. Finally, for audiology services, the state plan must reflect the supervision requirements as set forth at 42 CFR 440.110(c)(3).

Section 1915(i) of the Social Security Act

States can offer a variety of services under a section 1915(i) state plan Home and Community-Based Services (HCBS) benefit. The benefit may be targeted to one or more specific populations including individuals with ASD and can provide services and supports above and beyond those included in section 1905(a). Participants must meet state-defined criteria based on need and typically receive a combination of acute-care medical services (like dental services, skilled nursing services) and other long-term services such as respite care, supported employment, habilitative supports, and environmental modifications.

Other Medicaid Authorities

There are several other Medicaid authorities that may be used to provide services to address ASD. Below is a discussion of each of those authorities:

Section 1915 (c) of the Social Security Act

The section 1915(c) Home and Community-Based Services waiver program allows states to provide a combination of medical services and long-term services and supports. Services include

but are not limited to adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. Participants must meet an institutional level of care but are served in the community. Section 1915(c) waiver programs also require that services be furnished in home and community-based settings. For individuals under the age of 21 who are eligible for EPSDT services, an HCBS waiver could provide services and supports for ASD that are above and beyond services listed in section 1905(a), such as respite care. Additionally, for individuals who are receiving state plan benefits as part of EPSDT that are not available to adults under the state plan, waiver services may be used to help these individuals transition into adulthood and not lose valuable necessary services and supports.

Section 1115 Research and Demonstration Waiver

Section 1115 of the Act provides the Secretary of the Department of Health and Human Services broad authority to authorize experimental, pilot, or demonstration programs that promote the objectives of the Medicaid program. Flexibility under section 1115 is sufficiently broad to allow States to test substantially new ideas, including benefit design or delivery system reform, of policy merit. The Secretary can approve an 1115 demonstration for up to five years, and states may submit extension requests to continue the program for additional periods of time. Demonstrations must be "budget neutral" over the life of the program, meaning they cannot be expected to cost the Federal government more than it would cost without the demonstration.

EPSDT Benefit Requirements

Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. Good clinical practice requires ruling out any additional medical issues and not assuming that a behavioral manifestation is always attributable to the ASD. EPSDT also requires medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to assure that children get the health care they need, when they need it – the right care to the right child at the right time in the right setting.

The role of states is to make sure all covered services are available as well as to assure that families of enrolled children, including children with ASD, are aware of and have access to a broad range of services to meet the individual child's needs; that is, all services that can be covered under section 1905(a), including licensed practitioners' services; speech, occupational,

and physical therapies; physician services; private duty nursing; personal care services; home health, medical equipment and supplies; rehabilitative services; and vision, hearing, and dental services.

If a service, supply or equipment that has been determined to be medically necessary for a child is not listed as covered (for adults) in a state's Medicaid State Plan, the state will nonetheless need to arrange for and cover it for the child as long as the service or supply is included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act. This longstanding coverage design is intended to ensure a comprehensive, high-quality health care benefit for eligible individuals under age 21, including for those with ASD, based on individual determinations of medical necessity.

Implications for Existing Section 1915(c), Section 1915 (i) and Section 1115 Programs

In states with existing 1915(c) waivers that provide services to address ASD, this 1905(a) policy clarification may impact on an individual's eligibility for the waiver. Waiver services are separated into two categories: waiver services and extended state plan services. Extended state plan services related to section 1905(a) services are not available to individuals under the age of 21 (individuals eligible for EPSDT) because of the expectation that EPSDT will meet the individual's needs. There are therefore a limited number of services that can be provided to this age group under 1915 (c) waivers, primarily respite, and/or environmental/vehicle modifications.

For states that currently provide waiver services to individuals under age 21 to address ASD, the ability to provide services under the 1905(a) state plan may have the effect of making these individuals ineligible for the waiver unless another waiver service is provided. This implication is especially important for individuals with ASD who may not otherwise be eligible for Medicaid absent the (c) waiver. States need to ensure that these individuals are receiving a waiver service, not coverable under section 1905(a), to ensure that they do not lose access to all Medicaid services by losing waiver eligibility. Individuals age 21 and older may continue to receive services to address ASD through the waiver if a state does not elect to provide these services to adults under its Medicaid state plan.

The same issues arise for children under the 1915(i) authority, which allows for services above and beyond section 1905(a) to be provided under the state plan. CMS is available to provide technical assistance to states that currently have approved waivers or state plans that may be impacted by this clarification. Similarly, states with existing 1115 demonstrations authorizing reimbursement for services provided to children with autism should contact CMS to ensure that EPSDT requirements are met.

We hope this information is helpful. If you have questions please send them to AutismServicesQuestions@cms.hhs.gov.

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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. C. Authorize Contract for Behavioral Health Services with Windstone Behavioral Health for Cal MediConnect/OneCare Connect, and Extend the Current OneCare Contract

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

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel to:

1. Enter into a contract with Windstone Behavioral Health (Windstone) for the Cal MediConnect/OneCare Connect program for the period July 1, 2015 through ~~December 31~~, June 30, 2016. ~~with the option to renew for one additional year at CalOptima's sole discretion.~~ Revised 5/7/15
2. Amend the OneCare contract to extend it for one additional year (through calendar 2016), with the option to renew for one additional year at CalOptima's sole discretion. The current OneCare contract expires December 31, 2015.

Background and Discussion
Behavioral Health is a Medicare covered benefit for OneCare and OneCare Connect members. CalOptima currently contracts with Windstone to provide Medicare covered behavioral health services for the OneCare program. Windstone has been contracted with OneCare for behavioral health since January 1, 2007. The current contract is set to expire December 31, 2015, based on the previous contract extensions.

CalOptima's medical management and behavioral health staff have reviewed the utilization performance of this provider and also evaluated the access needs of CalOptima members, and determined that Windstone adequately meets CalOptima's requirements for the current OneCare program and future OneCare Connect program. At its January 2013 meeting, the CalOptima Board authorized the CEO to leverage the OneCare provider network as the basis for the Duals Delivery system. Therefore, staff recommends initiating a new contract for the OneCare Connect program, and renewing the current OneCare contract as indicated above.

Renewal of the OneCare contract will support the stability of CalOptima's contracted provider network should CalOptima decide to renew the OneCare program for 2016. The new contract for OneCare Connect will initiate a stable network with an already established provider. Contract language does not guarantee any particular volume and allows for CalOptima and the provider to terminate the contracts with or without cause.

Fiscal Impact
Based on forecasted OneCare and OneCare Connect enrollment for the extended contract periods, the fiscal impact of the recommended action is approximately $650,000 for OneCare and $2 million for OneCare Connect. Funding for the recommended actions will be included in the upcoming Fiscal Year 2015-16 CalOptima Consolidated Operating Budget.

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Rationale for Recommendation

CalOptima staff recommends authorizing an extension to OneCare's contract with Windstone to ensure that OneCare members continue to have access to covered services, and extending a new contract for the OneCare Connect program so that these members will also receive the same quality level of service.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *5/1/2015*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

7. Authorize Extension of the Cal MediConnect/OneCare Connect Contract with Windstone Behavioral Health for Behavioral Health Services; Authorize Contract for Consulting Services Related to Request for Proposal (RFP) Development and Delivery Model Optimization for the Behavioral Health Benefit

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Action

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:
    a. Extend the CalOptima-Windstone Behavioral Health Cal MediConnect/OneCare Connect contract for a six month period, through December 31, 2016, with the option to renew for one additional year (or two consecutive six month periods) exercisable at CalOptima's sole discretion; and
    b. Contract for up to $150,000 to hire a consultant through a Request for Proposal (RFP) process to determine the delivery model optimization for the behavioral health benefit and for the development of an RFP for contracted services, as appropriate.
2. Authorize budget allocation of $150,000 from the Medical Management department to the Behavioral Health Integration department.

Background/Discussion

Behavioral Health is a Medicare covered benefit for both OneCare and OneCare Connect members. In actions taken on May 7, 2015, the CalOptima Board of Directors authorized CalOptima staff to:

1. Enter into a contract with Windstone Behavioral Health (Windstone) for the Cal MediConnect/OneCare Connect program for the period July 1, 2015, through June 30, 2016, with direction that CalOptima staff would conduct a Request for Proposal (RFP) process by March 2016, to ensure that the best services are obtained for our members in a cost efficient manner; and
2. Extend the contract with CalOptima-OneCare Windstone for remaining OneCare members through December 31, 2016, with the option to renew for one additional year at CalOptima's sole discretion.

During the process of developing the RFP's Scope of Work for a Managed Care Behavioral Health Organization (MBHO), staff noted that the separate timing for implementation and transition of two MBHO contracts would potentially increase disruption of services for CalOptima OneCare and OneCare Connect members. Additionally, since the CalOptima Medi-Cal contract with CHIPA / Beacon Health Strategies expires on December 31, 2016, there is an opportunity to issue a single MBHO RFP that would potentially allow a single vendor to respond for OneCare, OneCare Connect, and Medi-Cal.

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In order to minimize disrupting services with multiple MBHO implementations and transitions for OneCare and OneCare Connect members, Staff recommends that the Board authorize extending the current OneCare Connect contract with Windstone through December 31, 2016 (a six month extension) to align with the OneCare and Medi-Cal contracts. Aligning these contract expiration dates would allow time to include the Medi-Cal MBHO in the RFP. In addition, Staff believes that it would be prudent to have the option of renewing the Windstone OneCare Connect contract for one additional year (or two consecutive six month periods) at CalOptima's sole discretion, should additional time be required to complete the selection process.

Extending the current contract will support the stability of CalOptima's contracted provider network and ensure continued services without disruption to OneCare Connect members until the RFP process has been completed. Contract language does not guarantee any particular volume and allows for CalOptima and the provider to terminate the contract with or without cause.

To assist in developing an RFP and determining how best to administer the behavioral health benefit, management proposes to engage a consultant. The consultant, to be selected consistent with CalOptima's Board-approved procurement policy, will help with the development of the RFP and to assist staff in evaluating the advisability and feasibility of building internal capacity to perform some or all of the behavioral health benefit functions. Activities in which the consultant would assist staff include, but are not limited to:

- Development/ refinement of an RFP
- Identifying organizations with the capacity to respond to the RFP
- Developing proposed scoring tool(s)
- Assessing proposals, panel review management
- Assisting in the selection process for a vendor
- Make recommendations on activities that should (or should not) be delegated to the proposed vendor(s)
- Provide support in the contract negotiation process

As future plans for the OneCare and OneCare Connect programs are finalized, staff will return to the Board to request authority to enter into future contracts/contract extensions for behavioral health and or consulting services as appropriate.

Fiscal Impact

Staff assumes the capitation rate included in the OneCare Connect Contract with Windstone Behavioral Health will remain unchanged under the contract extension, and will therefore be budget neutral to CalOptima. Funding for the recommended action will be included in the forthcoming Fiscal Year 2016-17 CalOptima Consolidated Operating Budget.

The recommended action to hire a consultant through an RFP process to determine the delivery model optimization for the behavioral health benefit and for the development an RFP for contracted services, as appropriate, is an unbudgeted item, and will be funded in an amount not to exceed

$150,000 of budgeted funds from the Medical Management department to the Behavioral Health Integration department.

Rationale for Recommendation

CalOptima staff recommends authorizing an extension to the OneCare Connect contract with Windstone to ensure that OneCare Connect members continue to have access to covered services, and to authorize contracting with a consultant to assist in optimizing the administration of the behavioral health benefit.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Previous Board action dated May 7, 2015

/s/ Michael Schrader *01/29/2016*
Authorized Signature **Date**

Attachment to:
February 4, 2016
Agenda Item 7

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Attachment to:
2/4/16, Agenda Item 7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. C. Authorize Contract for Behavioral Health Services with Windstone Behavioral Health for Cal MediConnect/OneCare Connect, and Extend the Current OneCare Contract

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel to:

1. Enter into a contract with Windstone Behavioral Health (Windstone) for the Cal MediConnect/OneCare Connect program for the period July 1, 2015 through ~~December 31~~, June 30, 2016. ~~with the option to renew for one additional year at CalOptima's sole discretion.~~ Revised 5/7/15
2. Amend the OneCare contract to extend it for one additional year (through calendar 2016), with the option to renew for one additional year at CalOptima's sole discretion. The current OneCare contract expires December 31, 2015.

Background and Discussion

Behavioral Health is a Medicare covered benefit for OneCare and OneCare Connect members. CalOptima currently contracts with Windstone to provide Medicare covered behavioral health services for the OneCare program. Windstone has been contracted with OneCare for behavioral health since January 1, 2007. The current contract is set to expire December 31, 2015, based on the previous contract extensions.

CalOptima's medical management and behavioral health staff have reviewed the utilization performance of this provider and also evaluated the access needs of CalOptima members, and determined that Windstone adequately meets CalOptima's requirements for the current OneCare program and future OneCare Connect program. At its January 2013 meeting, the CalOptima Board authorized the CEO to leverage the OneCare provider network as the basis for the Duals Delivery system. Therefore, staff recommends initiating a new contract for the OneCare Connect program, and renewing the current OneCare contract as indicated above.

Renewal of the OneCare contract will support the stability of CalOptima's contracted provider network should CalOptima decide to renew the OneCare program for 2016. The new contract for OneCare Connect will initiate a stable network with an already established provider. Contract language does not guarantee any particular volume and allows for CalOptima and the provider to terminate the contracts with or without cause.

Fiscal Impact

Based on forecasted OneCare and OneCare Connect enrollment for the extended contract periods, the fiscal impact of the recommended action is approximately $650,000 for OneCare and $2 million for OneCare Connect. Funding for the recommended actions will be included in the upcoming Fiscal Year 2015-16 CalOptima Consolidated Operating Budget.

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Rationale for Recommendation
CalOptima staff recommends authorizing an extension to OneCare's contract with Windstone to ensure that OneCare members continue to have access to covered services, and extending a new contract for the OneCare Connect program so that these members will also receive the same quality level of service.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

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A Public Agency

CalOptima

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Behavioral Health Integration - Managed Behavioral Healthcare Organization (MBHO) Vendor Selection

Board of Directors Meeting

September 1, 2016

Richard Helmer, M.D., Chief Medical Officer

Donald Sharps, M.D., Medical Director

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Today's Agenda

- Behavioral Health Services at CalOptima
- MBHO Functions
- BH Request for Proposal
- Evaluation Team
- Selection Criteria
- Evaluation Process
- Evaluation Result
- Next Step

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Behavioral Health Services at CalOptima

- OneCare (Medicare Duals Special Needs)
  - ➢Benefits began on January 1, 2007
- Medi-Cal Managed Care Plan
  - ➢Behavioral health benefits began on January 1, 2014
  - ➢Autism Spectrum Disorder Behavioral Health Treatment benefit began on September 15, 2014
- OneCare Connect (Duals Demonstration Project)
  - ➢Benefit began on July 1, 2015

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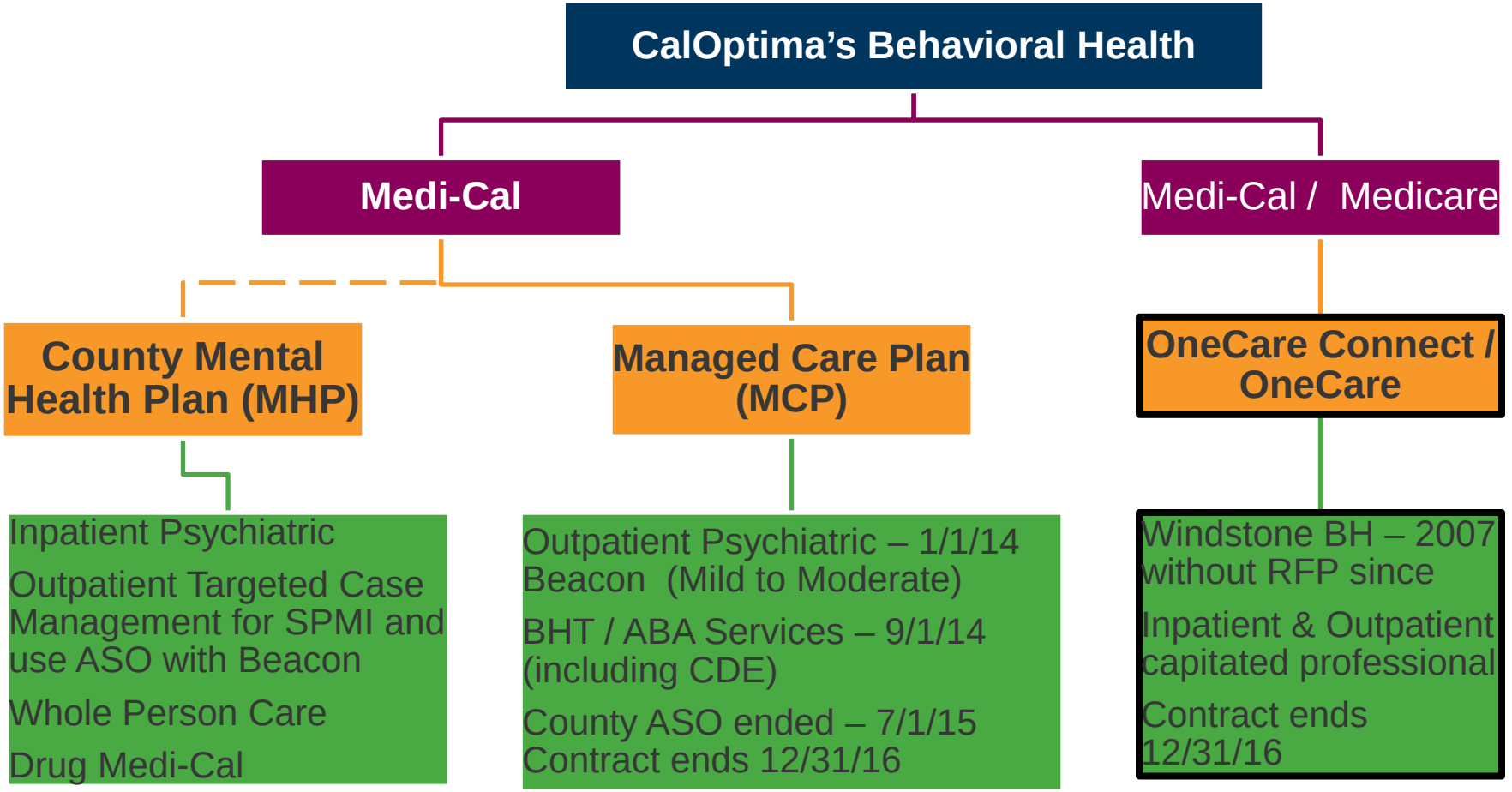
Behavioral Health Services at CalOptima



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Behavioral Health Services at CalOptima

- Behavioral Health (BH) services include services to address both mental health and substance use disorder conditions

- CalOptima is responsible for behavioral health services for all of its lines of business

- CalOptima has an opportunity to enhance the overall health of its members through the effective management of its behavioral health benefits

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Behavioral Health Services at CalOptima

- Like many managed care plans, CalOptima has used Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of BH benefits

Line of Business	Current Vendor
OneCare	Windstone Behavioral Health
OneCare Connect	Windstone Behavioral Health
Medi-Cal	CHIPA

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MBHO Functions

- MBHOs can support managed care plans by providing efficiency and subject matter expertise with:
  - BH Provider Network and Provider Relations
  - BH specific Credentialing
  - Call Center management
  - Eligibility verification
  - Level of care determinations
  - Claims payment and processing
  - Utilization management
  - Care management
  - Quality Improvement
  - Value based payment management

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BH Request for Proposal Timeline

Date	Key Steps
06/01/16	RFP released
06/29/16	Questions submitted from bidders*
07/15/16	Five bidders submitted proposal by deadline
07/20/16	RFP evaluation team met with CalOptima SME's
08/04/16	Completed scoring of written proposals
08/10/16	Bidder presentations to RFP evaluation team

* "CalOptima is requesting an at-risk (i.e. capitated) pricing model for each line of business"

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MBHO RFP Status - Evaluation Team

Proposals were evaluated by a collaborative team including CalOptima staff and HMA:

- Executive Director of Clinical Operations
- Behavioral Health Medical Director
- Director of Behavioral Health Services
- MAC member
- MAC OCC member
- PAC member

Additionally, only CalOptima staff scored specific sections of technical nature

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MBHO Selection Criteria – 21 Elements

- Experience in managed care
- Accreditation
- Corporate capabilities
- Information processing system*
- Financial management*
- Proposed staffing and project organization
- Ownership
- Outsourced services
- Provider network management and credentialing
- Operations
- Utilization management
- Claim processing*
- Grievances and appeals
- Care management
- Cultural competency
- Quality improvement
- Information technology, data management*
- Business intelligence*
- Compliance program
- Implementation plan
- Innovative program and services

* Technical Sections scored only by CalOptima staff

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MBHO Selection Process – Written Proposal

- The scoring tool contained 171 questions in 21 sections
  - Each question is scored on a scale of 1 to 5
- CalOptima Subject Matter Experts (SMEs) provided the evaluation team qualitative feedback
- CalOptima Staff also provided the evaluation team quantitative scores for the technical sections
- Weighted average score was calculated for each proposal

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MBHO Written Proposal Scores

Bidder Final Score Summary	Magellan	Envolve	CHIPA	Optum	Windstone
TOTAL Weighted	4.41	4.00	3.54	3.28	2.80
1.0 Experience and References	4.5	4.2	3.7	4.1	3.8
2.0 Accreditation	4.3	3.8	4.1	3.7	2.0
3.0 Corporate Capabilities	4.2	3.8	3.6	3.1	3.5
4.0 Information Processing System*	5.0	4.0	3.0	2.0	1.0
5.0 Financial Management*	4.0	4.0	3.0	4.0	2.0
6.0 Proposed Staffing and Project Organization	4.4	4.0	3.7	3.9	2.5
7.0 Ownership	3.7	3.1	2.9	3.7	3.0
8.0 Outsourced Services	N/A	N/A	3.5	2.3	N/A
9.0 Provider Network Management / Credentialing	4.6	4.7	3.8	3.5	3.6
10.0 Operations	4.2	4.0	3.0	2.7	2.7
11.0 Utilization Management	5.1	4.6	3.5	3.5	3.6
12.0 Claims Processing*	3.4	3.5	3.0	3.3	3.0
13.0 Grievances and Appeals	4.0	3.3	2.9	2.5	2.8
14.0 Care Management / Coordination	4.5	4.4	3.4	3.2	3.4
15.0 Cultural Competency	4.2	4.6	3.7	3.2	3.3
16.0 Quality Improvement	5.1	4.6	3.7	3.3	3.3
17.0 IT, Data Management, Electronic Data Exchange, and Health Information Exchange*	5.1	4.5	3.7	2.8	1.2
18.0 Business Intelligence*	4.6	4.4	4.4	4.4	1.3
19.0 Compliance Program	3.6	2.0	3.9	3.1	2.8
20.0 Implementation Plan	4.7	4.0	4.0	3.2	2.8
21.0 Innovative Programs & Services	4.7	4.5	4.2	3.4	4.4

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* Technical Sections scored only by CalOptima staff

MBHO Selection Process – Presentation

- The two bidders with highest written proposal scores, also
  1) Submitted bids for both Medi-Cal and Duals
  2) Had reasonableness of price
  3) Submitted bids with an at-risk (i.e. capitated) pricing model for each line of business
- Additional questions were submitted to these two bidders by the evaluation team and asked to present in person on 8/10/16

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MBHO Presentation Scores

Additional areas with follow-up questions from Evaluation Team	Magellan	ENVOLVE
1. Accreditation	3.71	1.00
2. Provider Network	4.14	3.33
3. Operations	4.71	3.50
4. Utilization Management	4.29	3.33
5. Grievances and Appeals	4.29	2.17
6. Care Management / Coordination	4.43	3.17
7. Quality Improvement	4.14	2.50
8. Reporting	5.00	2.20
9. Claims	4.57	2.83
Overall Average Score	4.36	2.67

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MBHO Selection Process – Additional Steps

- **Contract Language**
  - ➢Proposed changes reviewed
- **References**
  - ➢Reference checks completed and support the RFP scoring
- **Financial Review**
  - ➢Magellan and Envolve proposals were reviewed with Finance and determined to have a reasonable pricing model

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Rationale for Recommendation

- The evaluation team reviewed qualified MBHO responses and identified the candidate believed to best meet CalOptima's needs for:
  - Integration of care, regulatory compliance, operational efficiency, administrative simplification, best practices, as well as overall reasonableness of price
  - All delegated functions related to the Behavioral Health benefits: Customer Service, Care Management, Utilization Management, Credentialing, Quality Improvement, Claims Processing and Payment, Provider Dispute Resolution, Compliance and first level Provider Appeals

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Rationale for Recommendation

- CalOptima staff believes contracting with Magellan will meet CalOptima's goal of continuing to provide a comprehensive provider network and Behavioral Health and ASD services for CalOptima's Medi-Cal and Duals programs with:
  - Efficient and effective assessment, diagnosis, integrated care planning, strength based and person centered treatment implementation, support services and outcomes evaluation
  - Cultural responsiveness to our diverse membership, to develop a full picture of the various needs of the person and support goals and strategies to help members achieve and maintain recovery

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Next Steps

- Authorize the CEO to:
  - Enter into contract within 30 days with Magellan Health Inc.
  - Contract with a consultant(s) for up to $50,000 to assist with implementation
  - Extend the current CHIPA and Windstone contracts for up to six months, if necessary, to ensure no gap in coverage during the transition
- Direct CEO to return to the Board with further recommendations if contract is not finalized with Magellan within 30 days.

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CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
19. Consider Authorizing Amendment of the Data Center Collocation Facility Contract with the County of Orange

Contact
Len Rosignoli, Chief Information Officer, 714-246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to amend the existing contract with the County of Orange covering the use of the County of Orange Data Center Collocation facility to address updated pricing and to extend the term for an additional five (5) years with two (2) additional options to extend for one-year periods.

Background
Beginning in 1995, prior to beginning operations on October 1, 1995, CalOptima had a "computer room" in the former location on La Veta Avenue in Orange, California.

On May 6, 2010, the CalOptima Board of Directors authorized the relocation of the CalOptima computing infrastructure to a colocation facility. The reasoning was due to the growth experienced by CalOptima, requiring additional computing floor space, and to obtain the proper environmental infrastructure necessary to sustain a larger data center.

A review and evaluation process was conducted and at least four facilities within nearby Orange County were visited and evaluated. Ultimately, the County of Orange facility was selected due to proximity, value, and quality.

CalOptima's lease with the County of Orange took effect on September 19, 2010. The contract provides for an initial term of one (1) year, with the option to extend for two (2) additional one-year periods with the same terms and conditions. The initial lease provided 465 square feet of space at a monthly rent of $6,190 plus utilities. The move to the collocation facility was operational as of April 18, 2011.

The lease was amended on January 31, 2012 for the purpose of extending the agreement through February 29, 2016, with the option to extend for an additional two-year term with the same terms and conditions. The amendment increased the amount of dedicated space to 540 square feet, and the monthly rent to $8,123.86 plus utilities. The monthly rent is subject to annual adjustments based on rental rates determined by the County and approved by the Orange County Board of Supervisors. The amendment also established a base rental rate of $13.31 per square foot for any additional increases in floor space, and provided for $44,850 in system upgrades to be reimbursed from CalOptima to the County over the term of the lease. Consistent with the terms of the

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amendment, the option to extend this agreement for the final two years was exercised on February 23, 2016, and the arrangement currently expires on February 28, 2018.

Management believes that the physical and information security within the County of Orange data center is appropriate, in part considering the other government agencies that also use this collocation facility. The CalOptima section of the facility is managed exclusively by CalOptima staff.

Discussion/Recommendation

CalOptima has approximately three months remaining per the terms of the current agreement. This arrangement with the County of Orange has worked well for CalOptima. The current space is sufficient, there is room for expansion as needed, and the quality and security of the facility has met the needs of CalOptima.

The cost is reasonable and has been consistent over the past several fiscal years. The average monthly cost over the term of the agreement has been $18,914. The current invoices show approximately $11,000 in rent and $8,000 in utilities. The monthly fees included depreciation expense for the improvements made in 2012.

The proposed amendment would extend the agreement through February 28, 2023, with the option to extend for two one-year additional extension periods through February 28, 2025. As proposed, beginning March 1, 2018, the monthly base rent will be $13.81 per square foot, or $7,457.40 monthly, plus the cost of utilities. This represents an increase of $.50 per square foot – or approximately 3.6 percent. Beginning March 1, 2020, the monthly base rent will be $14.31, or $7,727.40. monthly, plus the cost of utilities.

Based on this information, and a strong partnership with the County of Orange facility, Management recommends a continuation of the current arrangement, and authority to extend the existing agreement with the County of Orange.

Fiscal Impact

The recommended action to extend the contract with the County of Orange to use the County of Orange Data Center Colocation facility is a budgeted item. Funding for the recommended action of up to $240,800 was included in the CalOptima FY 2017-2018 Operating Budget approved by the CalOptima Board of Directors on June 1, 2017. Management plans to include expenses related to the contract extension in future operating budgets.

Rationale for Recommendation

At this time, the existing data center colocation facility and arrangement meet the business needs of CalOptima. Considering that the existing arrangement is cost effectively meeting CalOptima's needs, management does not recommend considering an alternative colocation facility at this time.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Board Action dated May 6, 2010, Authorize Reallocation of Funds for Information Technology Process Integrity and for the Relocation of CalOptima Computing Infrastructure to a Colocation Facility
2. Letter from CalOptima exercising two-year extension dated February 23, 2016

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 6, 2010
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. A. Authorize Reallocation of Funds for Information Technology Process Integrity and for the Relocation of CalOptima Computing Infrastructure to a Colocation Facility

Contact

Eileen Moscaritolo, Executive Director, Information Services, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer to separate the CalOptima computing environment into two distinct computing components: Production and Test/Development; and,
2. Authorize the Chief Executive Officer to execute contracts to relocate CalOptima Production computing infrastructure to a colocation facility.

Background

CalOptima faces two Information Technology infrastructure challenges: 1) inadequate space in the current building; and, 2) a common processing environment that increases the risk of significant errors. Solutions to these two problems are related.

Inadequate Space

The current computer room for CalOptima was completed in 1995 at the same time the organization began operations with approximately 80 active employees. Since 1995 CalOptima has grown and the computer room now services over 420 active employees. Additionally, CalOptima has become a more complex organization incorporating additional core operating systems that help the departments operate more efficiently. The employees' technological needs have also changed requiring many to work outside of the physical building, but yet still be able to access company information stored via its secure computer systems. The CalOptima Information Services support staff has done an excellent job working within the physical and design constraints of the current computer room facility.

Over the past 15 years, CalOptima operationalized several large new business initiatives and has increased the amount of computing equipment and data needed to be protected and housed in the computer room. Due to our increased dependency on these systems to support our daily data needs, this has also increased the need to protect this section of the building from various higher risk levels and catastrophic failure scenarios that could severely impact the organization's ability to respond to business operations that are data intensive in nature.

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The major facilities and design issues that we have encountered are now being stretched to a breaking point. These issues include:

- increased heat loads being placed on the air conditioning units which were designed to cool office occupancy and medium sized computer room equipment;
- the creation of "ceiling temperature hot spots" effecting the office space in the floor above (i.e., the 4th floor which is occupied by a tenant other than CalOptima);
- the lack of floor space to place additional computer equipment needed to support organizational initiatives;
- the need to reinforce existing load bearing floor space to computer room load bearing specifications;
- the current over utilization of electrical power consumption that have led to hot spots needing to be addressed at the building breaker panels; and,
- the lack of redundant outside power sources to supply the computer room with non-street power in the event of public power outages.

Our current capabilities in this area will only allow us to function for up to 22 minutes – only enough time to bring the systems down in an orderly shutdown and forcing CalOptima to be placed in a position of not being able to conduct business servicing our members and providers during the normal business hours, including a loss of phone service.

Over the past twelve months, substantial effort has been undertaken to examine three options to mitigate our current data center issues. First, we worked with our landlord and building consultants to develop an expansion plan for our existing facility. Second, we worked with a Real Estate firm to identify potential pre-existing data centers that could be purchased or leased for our use. Both of these options were found to require a significant amount of capital expenditures ranging into the millions of dollars and significant time horizons stretching over a year to complete. The third option we analyzed was colocation. This option is more attractive in terms of cost and implementation timeframe, as well as providing us with the most flexibility to address future needs.

Common Processing Environment

One of the biggest exposures from an Information Services (IS) perspective is that "production" computer systems with its associated production data that are used for all daily operational activities are being housed in the same physical computer room as "test and development" systems with its associated data information. Although this is not an issue when a computer room is physically large enough to segregate these two environments via physical and logical boundaries, this is a large risk to undertake when the physical and logical proximity are so close together as to potentially cause "comingling" placement situations to occur. According to best industry practice, these types of situations are strongly discouraged, as they can lead to greater risk to the organization in the area of security violations, cross contamination of computing environments, and potential use of test/development

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environments being used for production use. Separation of production and test/development environments will require the purchase of additional equipment

As a result of these challenges, management is recommending that CalOptima's production computer systems be moved to a colocation environment.

Discussion

What is Colocation?
Colocation (also known as 'co-location') is a service where a large data center facility is physically and logically segregated to house many companies' data center needs in a common shared and secure physical space. It is not the comingling of data center environments but rather like an apartment, the sharing of common building infrastructure in a separated manner. Each company's equipment is physically secured in a wire cage or cabinet with high security locking systems and security tracking systems. Additionally the network is segregated into private virtual networks, so no data is mixed with other company's information as it is transmitted across the colocation business network; similar to what is currently being done today at CalOptima. Additionally, CalOptima will benefit from improved network security from a state-of-the-art network security infrastructure, including the ability to detect and prevent unauthorized intrusion into our core applications.

Why Colocation?
Colocation can offer CalOptima several key advantages with regard to time and money:

- CalOptima concern about recurring capital/expense costs will be less if we are adding/eliminating computing equipment as we rent/dispose of space as our business needs dictate.
- CalOptima will no longer have to be concerned with the day-to-day maintenance activities associated with the monitoring of heat issues, power consumption, facility security, fire suppression, or extended off grid power needs due to public power outages.
- CalOptima will be positioned for on demand network connectivity from a broader based list of service providers.
- CalOptima IS and facility personnel refocus on core IS and facility activities, rather than being stretched to acquire additional skills sets that are not core to their business service charters – but are needed to be acquired to perform these additional duties.

Who uses Colocation data centers?
The general answer is small to midsize organizations, like CalOptima whose business continuity is dependent on smooth access to flow of data and for whom system downtime is not an option. Additionally, this model is used by businesses which cannot justify the large

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front end capital investments, time and expenditures needed to create their own data center environments with the associated reoccurring costs.

Although many improvements have occurred to the existing CalOptima data center over the years resulting in extending the reliability of the facility, the time has now come for a different business technology approach. Over the past few months, staff along with outside subject matter consultants has recommended initiating the process for relocation of key computing infrastructure to start at this time.

Fiscal Impact

The overall anticipated cost for the two projects (colocation and separation of production from test/development environments) is not expected to exceed $1.1 million in the next 12 months.

1. Rent for the new colocation facility is expected to be no more than $300,000 annually and is included in the proposed FY 2010-11 budget.

2. Capital costs associated with the segregation of the production and test/development environments are projected at $660,000. The need for these capital dollars is independent of the decision to colocate.

   There are adequate unspent dollars remaining from the FY 2009-10 capital budget to cover these capital costs, so no incremental capital dollars are required. The savings in the FY 2009-10 budget are associated favorable contracting terms for the PBX installation, completing the Online Authorization tool under budget, and deferring other smaller projects due to resource constraints.

3. Hardware maintenance expense associated with the above mentioned capital is reflected in the FY 2010-11 budget at an amount of approximately $145,000.

Rationale for Recommendation

For CalOptima, colocation offers an immediate cost and timely delivery of benefits for services needed when compared to creating and maintaining a new computer room environment to support this work in-house. Choosing this service is practical for our organization due to the physical space limitations and major building upgrades needed to augment our current computer room facility. It also provides the continued option of revisiting this situation and gives the Board flexibility to reconsider doing this as an in-house function if future business needs warrant the upfront costs associated with an in-house solution. It also provides the ability to continue to service less critical test and development systems in-house and within the original design specifications. This strategy will also allow

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us to continue to leverage the past investments made in the computer room to service this portion of the IS service portfolio.

Thus, based on the increased demand for air conditioning to address the computer room heat issue, power redundancy needs, computer Production and Test/Development environment separation needs and overall computer room space and monitoring environment, staff recommends that the Board authorize the Chief Executive Office to separate the CalOptima computing environment into two distinct computing components: Production and Test/Development; and, authorize the execution of contracts to relocate CalOptima Production computing infrastructure to a colocation facility.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachment
Colocation Financial Analysis

/s/ Richard Chambers — *4/29/2010*
Authorized Signature — **Date**

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Colocation (Colo) Seed Funding with Potential Offsets from FY 11 Budget Item Requests If Approved - Initial Colo Space 1000 sq/ft			
CAPITAL Categories and Items	**Qty**	**Item Cost**	**Item Total**
Network Communication Costs			
Dedicated pair of routers for site to site communication at Orange	2	$15,000	$ 30,000
Dedicated pair of routers for site to site communication at JW colo site	2	$15,000	$ 30,000
Dedicated pair of switches for servers at JW colo site	1	$75,000	$ 75,000
Racks for network equipment	2	$2,500	$ 5,000
Pair of core switches for colo	2	$70,000	$ 140,000
Network connection between Orange and JW Airport 50 megbytes qty 1	2	$44,000	$ 88,000
Subtotal			$ 368,000
Server Infrastructure Costs			
SAN Switches	2	$25,000	$ 50,000
Data replication software temp license key/professional services	1	$20,000	$ 20,000
Tape library	1	$50,000	$ 50,000
Com vault license	1	$5,000	$ 5,000
Blade Enclosure	1	$81,000	$ 81,000
Com vault media server	1	$7,000	$ 7,000
Colo operator time for tape	1	$20,000	$ 20,000
XenApps/XenSVR Blade servers	2	$7,000	$ 14,000
Subtotal			$ 247,000
MISC EXPENSE FUNDS REQUEST - Sales Tax, Professional Fees, Equpment Moves from OC, etc.			$ 45,000
One-Time Colo Costs		**GRAND TOTAL**	$ 660,000
Leverage of Request from FY 11 Capital Budget to be used in Colo Project IF Budget Items ARE Approved			
C025 Disk Array for Test/Development System			$ (110,000)
C039 HP C-Class Blade Enclosure			$ (50,000)
Backup infrastructure for colocation			$ (100,000)
Network infrastructure for colocation			$ (250,000)
San Disk System for colocation			$ (150,000)
FY11 BUDGET ITEMS REQUEST - Leveraging for Project			$ (660,000)
SUMMARY OF COLOCATION PROJECT COSTS			
One Time Colo Costs Capital/Additonal Expense Dollars Requested - Grand Total			$ 660,000
Colocation Rent Cost from FY 11 Budget Expense Request put into FY 11 Budget			$ 300,000
Relocation Project Year One Cost			$ 960,000

General Colo Project Considerations for FY '11

Phase 1 - FY 11 Projects

Potential FY 11 Candidate applications

Facets - Install new facets servers to colo for October launch

CCMS- Migrate current FACETS in Nov & move to colo for New CCMS upg build in 2011

Create Citrix Infrastructure for CCMS and Facets only

Install DataWarehouse environments (outlined in FY 11) to colo

Assumptions Used for FY 10-11 Phase 1 Activities

1. Racks requested in FY 11 budget if approved
2. Citrix license requested in FY 11 if approved
3. Citrix hardware requested in FY 11 if approved
4. Colo would need for data circuits to be in Time Warner svc area
5. Development switch in FY 11 if approved
6. HP cClass Blade enclosure in FY 11 if approved
7. Disk Array for Test/Dev environment in FY 11 if approved

Phase 2 - FY 11-12 Potential Items to consider

Internet website

PBX - Assuming that PBX would stay in 714 area code in colo site

Email

RISS

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CalOptima
A Public Agency
Better. Together.

February 23, 2016

Duane Bankey
Supervising Manager, Budget/Finance and Contracts
Orange County Information Technology
1501 E. St. Andrew Pl., 2nd Floor
Santa Ana, CA 92705

OBJECT: LEASE EXTENSION

Dear Mr. Bankey,

Pursuant to Section 7, Option to Extend Term (N), of the First Amendment to Lease entered into on January 21st, 2012, CalOptima is exercising its option to extend the Lease with OCIT for an additional Two (2) years through February 28, 2018 at the same terms and conditions.

We request that you send a written reply acknowledging receipt and acceptance of this renewal notification.

Sincerely,

Ryan Prest
Manager, Purchasing
714-347-3235
rprest@caloptima.org

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
20. Consider Authorization of Extension of Existing Contract with Edelstein Gilbert Robson & Smith for State Legislative Advocacy Services

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to extend the existing contract with state legislative advocate Edelstein Gilbert Robson & Smith (EGR&S) for six months, through June 30, 2018.

Background
EGR&S has represented CalOptima for state advocacy services in Sacramento since 2001. The current contract expires on December 31, 2017. As part of CalOptima's routine procurement process, staff initiated a Request for Proposal (RFP) process for state advocacy services in August 2017. In addition, at the September Board of Director's meeting, the Chair established a Board Ad Hoc review committee, consisting of Supervisor Bartlett, Director Berger, Supervisor Do, and Director Khatibi, to provide guidance and make recommendations on the selection of a state advocacy services firm.

Discussion
Staff released the state advocacy services RFP in August 2017 with proposals due from interested firms by October 2, 2017. CalOptima received two proposals, and an RFP evaluation committee consisting of both staff and external subject matter experts reviewed and evaluated the proposals. The two firms are being asked to participate in interviews conducted by the Board Ad Hoc committee.

These Board Ad Hoc-led interviews are expected to take place as soon as in January 2018, and will be followed by recommendation to the full Board at a future Board meeting. However, because the current state advocacy contract expires at the end of the calendar year and to ensure that CalOptima has uninterrupted representation in Sacramento, staff recommends that the Board authorize an extension of the current contract with EGR&S for six additional months, through June 30, 2018.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2017-18 Operating Budget approved by the Board on June 1, 2017, included professional fees for state advocacy services. Assuming continuance of the terms of the current contract, the recommended action to extend the contract for the state advocacy services firm for up to six months is a budgeted item with no additional fiscal impact.

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Rationale for Recommendation

Staff recommends extension of the current contract with EGR&S for six additional months, through June 30, 2018, to allow time to select a state legislative advocacy services firm, based on the current state advocacy services RFP process.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

21. Consider Authorizing the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program for Rate Year 2017-18 (IGT 8)

Contact

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

Recommended Actions

1. Authorize submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Intergovernmental Transfer (IGT) Rate Range Program for Rate Year 2017-18 (IGT 8);
2. Authorize 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 Intergovernmental Transfer (IGT) Rate Range Program for Rate Year 2017-18 (IGT 8), and;
3. Authorize the CalOptima Board Chair and/or Vice Chair to execute agreements with these entities and their designated providers as necessary to seek IGT 8 funds.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in seven Rate Range IGT transactions. Funds from IGTs 1 – 6 have been received and IGT 7 funds are expected in the first quarter of 2018. IGT 1 – 7 funds were retrospective payments for prior rate range years and have been used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. These funds have been best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

The IGT funds that have been secured to date have supported special projects that address unmet needs for CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing unmet needs.

Discussion

In November, CalOptima received notification from DHCS regarding the State Fiscal Year (SFY) 2017-18 Voluntary Rate Range Intergovernmental Transfer Program (IGT 8).

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The notification outlined some changes to the upcoming IGT process which include:

- The rate range IGT 8 program covers the current fiscal year and funds will be incorporated into the contract between DHCS and CalOptima for the period of July 1, 2017 – June 30, 2018. Unlike previous IGTs, IGT 8 funds must be used in the current rate year for CalOptima covered services.
- CalOptima can decide how to spend the IGT funds (net proceeds) as long as they are for CalOptima covered services for Medi-Cal beneficiaries and used by June 30, 2018.

Five eligible funding entities have been identified and staff is in the process procuring letters of interest regarding participation in the IGT program. 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 submit a proposal letter to DHCS for participation in the 2017-18 Voluntary IGT Rate Range Program and to enter into agreements with the five proposed funding entities or their designated providers for the purpose of securing available IGT funds. Consistent with the seven prior IGT transactions, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Notification from DHCS of the IGT Rate Range Program for Rate Year 2017-18 (IGT 8) was received November 8, 2017. CalOptima's proposal, along with the funding entities' supporting documents are due to DHCS on December 14, 2017. Staff will return to your Board with more information regarding the IGT 8 transaction and an expenditure plan for CalOptima's share of the net proceeds later this fiscal year.

Fiscal Impact

The recommended action to pursue a proposal with DHCS and agreements with five governmental funding entities for IGT 8 is expected to generate a one-time IGT revenue, which will be utilized for Medi-Cal covered services. The amount of IGT funding is not known at this time, and will be a function of the level of funding contributed by participating entities. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. As such, there is no net fiscal impact on CalOptima's current and future operating budgets.

Rationale for Recommendation

Consistent with the previous seven IGT transactions, authorization of the proposal and funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2017-18 (IGT 8).

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

/s/ Michael Schrader *11/30/2017*
Authorized Signature **Date**

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

NOV 15 2017

Greg Hamblin
CFO
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: State Fiscal Year (SFY) 2017-18 Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Greg Hamblin:

The 2017-18 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of July 1, 2017 through June 30, 2018 (SFY 2017-18).

DHCS shall not direct the MCP's expenditure of payments received under the 2017-18 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 ~~contracted~~ **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.

Capitated Rates Development Division
1501 Capitol Avenue, P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413
Phone (916) 322-5831
www.dhcs.ca.gov

PROCESS FOR SFY 2017-18:

MCPs should refer to the estimated SFY 2017-18 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 2017-18 Voluntary Rate Range Program is voluntary. While participation is encouraged, funding for the entire rate range amount may not be available. If that occurs, the capitation rates to be incorporated in the MCP's contract with DHCS will reflect only the actual transfer amounts.

If an MCP elects to participate in the 2017-18 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 2017-18 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. 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 fund the full amount of their portion of the non-federal share of the capitation rate range, the MCP shall attempt to find other governmental funding entities able and willing to fund the differential.

The MCP must inform all participating governmental entities that, unless 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. A governmental funding entity may request such an exemption via the SFY 2017-18 Voluntary Rate Range Program Supplemental Attachment (see Attachment B). DHCS will evaluate requests to determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.
2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for SFY 2017-18. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the "supplemental attachment" described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** (using the format provided in Attachment A) from each governmental funding entity included in the MCP's proposal to DHCS. An individual authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest. Each letter of interest must specify:

  1. The governmental funding entity's name and Federal Tax Identification Number,
  2. The dollar amount or percentage of the total available rate range the governmental funding entity will contribute for each MCP and county/region, and
  3. The governmental funding entity's primary contact information (name, e-mail address, mailing address, phone number).

- The MCP must distribute to governmental funding entities and ensure submission to DHCS of the **SFY 2017-18 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Thursday, December 14, 2017.

- The proposals and letters of interest are due to DHCS ***by 5pm on Thursday, December 14, 2017***. Please send a PDF copy of the required documents by e-mail to Sandra.Dixon@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the SFY 2017-18 Voluntary Rate Range Program.***

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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 2017-18 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) 552-9460 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,

Jennifer Lopez
Acting Division Chief
Capitated Rates Development Division

Attachments

cc: Michael Schrader
CEO
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Financial Management Section
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

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ATTACHMENT A – LETTER OF INTEREST TEMPLATE

Jennifer Lopez
Acting 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 provide an Intergovernmental Transfer (IGT) to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the period of July 1, 2017, to June 30, 2018. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

_Insert Participating Funding Entity Name is willing to contribute up to $_____ for the SFY 2017-18 rating period as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,
Signature

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Attachment B

SFY 2017-18 Voluntary Rate Range Program Supplemental Attachment

Provider Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by Thursday, December 14, 2017.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2016 through June 30, 2017.

	Charges	Costs	Payments from Health Plan*	Uncompensated Chares (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$	$
Outpatient				$	$
All Other				$	$
Total	$	$	$	$	$

* Include payments received and anticipated to be received for service dates of July 1, 2016 through June 30, 2017.

2. Unless a statutory exemption applies, Intergovernmental Transfers (IGTs) submitted in accordance with Welfare and Institutions Code (W&I Code), section 14301.4, are subject to an additional 20% assessment fee (calculated on the value of the IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Rate Range Program and to support the Medi-Cal program.

Are you requesting a waiver of the 20% assessment fee authorized under W&I Code, section 14301.4? *(Yes / No)*

If Yes, please specify the basis for the waiver request:

3. Are you able to fund 100% of the uncompensated charges or uncompensated costs (as stated above)? *(Yes / No)*

If No, please specify the amount of funding available:

4. 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.

5. For any capitation payments to be funded by the IGT, please provide the following:

(i) The name of the entity transferring funds:

(ii) The operational nature of the entity (state, county, city, other):

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations.)

(iv) Does the transferring entity have general taxing authority? *(Yes / No)*

(v) Does the transferring entity receive appropriations from a state, county, city, or other local government jurisdiction? *(Yes / No)*

6. Comments / Notes

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ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

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CalOptima - Orange County (HCP 506)
IGT - 2017/18 (July 2017 - June 2018)

	Total	50% FMAP (Non-MCHIP and OE)	88% FMAP (MCHIP)	95% Optional Expansion (7/2017 - 12/2017)	94% Optional Expansion (1/2018 - 6/2018)
Upper Bound w/o MCO Tax (SBx2 2)	$2,502,805,302	$1,103,586,372	$131,690,856	$ 633,764,037	$ 633,764,037
Lower Bound w/o MCO Tax (SBx2 2)	$2,377,349,117	$1,046,069,061	$124,391,340	$ 603,444,358	$ 603,444,358
Total Funds Available	$ 125,456,185	$ 57,517,311	$ 7,299,516	$ 30,319,679	$ 30,319,679
Federal Match	$ 92,486,423	$ 28,758,656	$ 6,423,574	$ 28,803,695	$ 28,500,498
Governmental Funding Entity's Portion	$ 32,969,762	$ 28,758,656	$ 875,942	$ 1,515,984	$ 1,819,181
	26%	50%	12%	5%	6%

7/1/2017 - 12/31/2017

	Member Months **	Upper Bound w/o MCO Tax ***	Lower Bound w/o MCO Tax ***	Upper Bound w/o MCO Tax	Lower Bound w/o MCO Tax	Difference
Child - non MCHIP	1,291,074	$ 92.32	$ 87.20	$ 119,188,681	$ 112,575,794	$ 6,612,887
Child - MCHIP	640,062	$ 92.32	$ 87.20	$ 59,088,903	$ 55,810,502	$ 3,278,400
Adult - non MCHIP	582,510	$ 285.37	$ 269.69	$ 166,233,472	$ 157,096,814	$ 9,136,658
Adult - MCHIP	23,676	$ 285.37	$ 269.69	$ 6,756,526	$ 6,385,168	$ 371,358
SPD	245,430	$ 797.94	$ 755.43	$ 195,838,257	$ 185,406,039	$ 10,432,219
SPD Full Dual	246	$ 164.90	$ 157.17	$ 40,566	$ 38,664	$ 1,902
BCCTP	3,546	$ 1,294.19	$ 1,223.32	$ 4,589,184	$ 4,337,902	$ 251,282
LTC	6,948	$ 9,485.18	$ 9,150.74	$ 65,903,026	$ 63,579,318	$ 2,323,708
LTC Full Duals	-	$ 5,778.00	$ 5,594.72	$ -	$ -	$ -
OBRA						
Optional Expansion	1,414,494	$ 448.05	$ 426.62	$ 633,764,037	$ 603,444,358	$ 30,319,679
	4,207,986	$ 297.39	$ 282.48	$ 1,251,402,651	$ 1,188,674,558	$ 62,728,093

1/1/2018 - 6/30/2018

	Member Months **	Upper Bound w/o MCO Tax ***	Lower Bound w/o MCO Tax ***	Upper Bound w/o MCO Tax	Lower Bound w/o MCO Tax	Difference
Child - non MCHIP	1,291,074	$ 92.32	$ 87.20	$ 119,188,681	$ 112,575,794	$ 6,612,887
Child - MCHIP	640,062	$ 92.32	$ 87.20	$ 59,088,903	$ 55,810,502	$ 3,278,400
Adult - non MCHIP	582,510	$ 285.37	$ 269.69	$ 166,233,472	$ 157,096,814	$ 9,136,658
Adult - MCHIP	23,676	$ 285.37	$ 269.69	$ 6,756,526	$ 6,385,168	$ 371,358
SPD	245,430	$ 797.94	$ 755.43	$ 195,838,257	$ 185,406,039	$ 10,432,219
SPD Full Dual	246	$ 164.90	$ 157.17	$ 40,566	$ 38,664	$ 1,902
BCCTP	3,546	$ 1,294.19	$ 1,223.32	$ 4,589,184	$ 4,337,902	$ 251,282
LTC	6,948	$ 9,485.18	$ 9,150.74	$ 65,903,026	$ 63,579,318	$ 2,323,708
LTC Full Duals	-	$ 5,778.00	$ 5,594.72	$ -	$ -	$ -
OBRA						
Optional Expansion	1,414,494	$ 448.05	$ 426.62	$ 633,764,037	$ 603,444,358	$ 30,319,679
	4,207,986	$ 297.39	$ 282.48	$ 1,251,402,651	$ 1,188,674,558	$ 62,728,093
Total	8,415,972			$ 2,502,805,302	$ 2,377,349,117	$ 125,456,185

*	Child - non MCHIP	Child - MCHIP	Adult - non MCHIP	Adult MCHIP	SPD	SPD Full Dual	BCCTP	LTC	LTC Full Duals	OBRA	Optional Expansion	Total
Jul-16	222,074	107,819	103,204	3,265	41,120	49	603	1,066	1		229,628	708,829
Aug-16	221,437	107,829	102,381	3,480	41,057	48	599	1,083	1		230,885	708,800
Sep-16	221,233	108,789	102,074	3,649	41,116	45	595	1,080	0		228,022	706,603
Oct-16	221,113	109,159	102,305	3,876	41,268	50	590	1,092	0		230,637	710,090
Nov-16	219,552	109,159	101,149	4,025	41,026	47	598	1,095	0		231,824	708,475
Dec-16	219,012	109,292	100,656	4,189	41,105	48	596	1,117	0		233,601	709,616
Jan-17	218,012	107,307	99,126	4,102	41,148	46	586	1,131	0		234,043	705,501
Feb-17	216,276	105,887	97,737	4,012	41,225	44	589	1,138	0		234,233	701,141
Mar-17	216,196	106,064	97,459	3,958	41,240	42	587	1,145	0		235,959	702,650
Apr-17	214,250	106,526	96,445	3,871	41,040	39	592	1,164	0		236,216	700,143
May-17	213,282	106,622	95,985	3,878	40,597	37	594	1,174	0		236,642	698,811
Jun-17	213,059	107,653	95,760	3,854	40,181	36	595	1,193	0		237,403	699,734
	2,615,496	1,292,106	1,194,281	46,159	492,123	531	7,124	13,478	2		2,799,093	8,460,393

*	Child - non MCHIP	Child - MCHIP	Adult - non MCHIP	Adult MCHIP	SPD	SPD Full Dual	BCCTP	LTC	LTC Full Duals	OBRA	Optional Expansion	Total
Jul-17	215,179	106,677	97,085	3,946	40,905	41	591	1,158	0		235,749	701,331
Aug-17	215,179	106,677	97,085	3,946	40,905	41	591	1,158	0		235,749	701,331
Sep-17	215,179	106,677	97,085	3,946	40,905	41	591	1,158	0		235,749	701,331
Oct-17	215,179	106,677	97,085	3,946	40,905	41	591	1,158	0		235,749	701,331
Nov-17	215,179	106,677	97,085	3,946	40,905	41	591	1,158	0		235,749	701,331
Dec-17	215,179	106,677	97,085	3,946	40,905	41	591	1,158	0		235,749	701,331
Jan-18	215,179	106,677	97,085	3,946	40,905	41	591	1,158	0		235,749	701,331
Feb-18	215,179	106,677	97,085	3,946	40,905	41	591	1,158	0		235,749	701,331
Mar-18	215,179	106,677	97,085	3,946	40,905	41	591	1,158	0		235,749	701,331
Apr-18	215,179	106,677	97,085	3,946	40,905	41	591	1,158	0		235,749	701,331
May-18	215,179	106,677	97,085	3,946	40,905	41	591	1,158	0		235,749	701,331
Jun-18	215,179	106,677	97,085	3,946	40,905	41	591	1,158	0		235,749	701,331
	2,582,148	1,280,124	1,165,020	47,352	490,860	492	7,092	13,896	0		2,828,988	8,415,972

* Member Months as of October 9, 2017 MIS DSS – 2017-18 enrollment projections based on actual average enrollment for January 2017 - June 2017.
** The supplemental payments (BHT and HEP C) are not included in the rate range calculation.
*** Final rate range that will be calculated based off of the final SFY 2017-18 base rates with out MCO tax. Due to timing constraints, estimated rate ranges are listed above which include the Non-Medical Transportation but do not include the removal of Indian Health Services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Actions Related to CalOptima's Development Agreement with the City of Orange

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Receive and file the Property and Associated Development Rights Request for Information (RFI) results, dated April 21, 2017, that relate to property covered by CalOptima's existing development agreement at the 505 City Parkway West project site;
2. Authorize the Chief Executive Officer (CEO) to: ~~complete a Request for Proposal (RFP) process to select a real estate development consultant to assist CalOptima in:~~
    a. Contact the City of Orange (City) to explore:
        i. Extending CalOptima's existing development agreement for as long as possible (e.g., through 2026);
        ii. Broadening CalOptima's rights under the development agreement from commercial/office to include urban mixed use, including transitional housing; ~~the current Development Agreement with the City of Orange, which covers an office tower of up to 10 stories and a 1,528 space parking structure~~
    b. After confirming that the City is amenable to the proposed changes: ~~Developing a plan for moving forward with a parking structure~~
        i. Initiate a RFI process on development options for the site assuming the use of no Medi-Cal dollars and including a parking structure;
        ii. Seek assistance from the County of Orange Real Estate (Development Services) Department, as appropriate.
    c. ~~Conducting analysis and making recommendations on permissible options for further development of the site (e.g., Mixed Use, etc.), along with potential costs and funding mechanisms that would be associated with the exercise of each option.~~

Rev. 12/7/17

Background
At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to 10 stories and 200,000 square feet of office space, and a parking structure of up to five levels and 1,528 spaces. The office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the 505 City Parkway West building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014, meeting, the CalOptima Board of Directors authorized an amended and restated Development Agreement with the City of Orange to extend CalOptima's development rights for six

years, until October 28, 2020. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. CalOptima agreed to pay a required $200,000 public benefit fee to the City of Orange in exchange for the extension.

In 2016, at its August 4th and December 1st meetings, the Board authorized contracts with real estate consultant Newport Real Estate Services, Inc. to evaluate options for CalOptima's current development rights and to create a site plan. Newport Real Estate Services completed this analysis and presented the requested information to the Board's Finance and Audit Committee (FAC) in February 2017, and FAC recommended that the Board authorize issuance of a Property and Associated Development Rights Request for Information (RFI). The RFI was designed to gauge potential interest in and options for CalOptima's development rights. The Board approved the issuance of an RFI at its March 2, 2017, meeting.

By the close of the RFI response period on April 21, 2017, only one response had been received, from Trammel Crow Company. The RFI was narrowly focused on office space and parking, as per the current Development Agreement. This limited response to the RFI, as well as other informal discussions with industry representatives during the RFI process, may reflect the real estate community's limited level of interest in commercial office space at this time.

Discussion

In the years since the purchase of 505 City Parkway West, CalOptima's membership has grown significantly with the implementation of the Affordable Care Act. And while membership has been essentially stable in 2017, the operational and oversight demands have continued to grow, as have the number of programs the state has folded into the Medi-Cal managed care plans, in large part due to their member focus and cost effectiveness. While approximately 10% of the available 505 building workstations are currently unoccupied, the building is currently fully occupied as this "flex space" is critical to the Facilities Department's efforts to optimize available workspace to maximum workforce productivity (e.g., placing employees in a particular department in the same area/on the same floor of the building).

While CalOptima's existing office tower and employee workspaces are meeting current needs (with nearly one third of the staff in telework positions), it is anticipated that longer term, additional space may be required to meet the organization's needs. In the immediate term, parking is a pressing issue, with available spaces marginally adequate to meet parking needs during peak hours of operations. While management has explored a number of options to reduce the need to parking (e.g., further expansion of the telework program, carpools, vanpools, flexible start times, supporting alternative transportation, etc.), the need for additional parking is an increasingly pressing issue. One approach under consideration would be to recommend development of the parking structure initially, with a decision on the office tower development rights addressed at a later date.

Regarding the potential development of a second ten story office tower at this time, with the assumption that it would at least initially be partially occupied by third parties, various market factors suggest that growth in demand for professional office space by third party tenants in the North Orange County region appears somewhat limited, though in the immediate area, virtually all available commercial space is currently occupied. According to a Second Quarter 2017 analysis by Colliers

International, market activity has slowed compared with the past two years. Staff's understanding is that average lease rates in the North Orange County area remain at approximately $2.23 per square foot, which is below their 2007 peak. Staff also believes that, while there are a number of large developments in the works for central Orange County, the majority of new, large scale professional office projects in the county are proposed within the John Wayne Airport and South Orange County areas as opposed to the North Orange County region. These trends may limit the value of CalOptima's current Development Agreement if the decision is to develop the site as a 10-story commercial building that will, in part, be leased to third parties.

To ensure that a comprehensive review process is completed before a decision is made on the best use of the new tower site, staff is recommending that the Board obtain the expertise of a real estate development consultant to evaluate the potential value of a revised Development Agreement that would allow for other potential uses such as, for example, Urban Mixed-Use zoning, which would include commercial retail and housing uses. While this approach may result in the facility being sold to a third party, it assumes that CalOptima will make other arrangements to meet any increases in need for office space as the current facility is near capacity today. Though it is possible that the commercial vacancy rate in the area may increase in the future, when CalOptima was considering additional space approximately two years ago, very limited space was available within several miles of the 505 building. At this stage, one possible approach the consultant could explore would be to focus on prioritizing the additional parking space now, and either seeking an extension of the remaining rights as further study is completed on the available options, or estimating the cost of seeking a change to the Development Agreement to allow for Mixed Use zoning. Another option would be to sell the rights to a third party who may be interested in exercising the existing development rights, or pursuing a change with the City of Orange.

Fiscal Impact
The FY 2016-17 Board-approved CalOptima Medi-Cal operating budget includes $37,000 for Real Estate Consultant services. In addition to this amount, once the scope of work for the consultant is developed, staff will return to Board with an estimate of additional costs.

California Welfare and Institutions Code section 14087.54, CalOptima's enabling statute, provides that CalOptima was established to "meet the problems of delivery of publicly assisted medical care in the county… and to demonstrate ways of promoting quality care and cost efficiency." The statute also includes provisions limiting the use of "any payment or reserve from the Medi-Cal program" to administration of the Medi-Cal program itself. Consequently, alternative funding (i.e., from a source other than CalOptima) would be an essential element of any recommendation to use the development rights for some purpose not specifically related to CalOptima's administration obligations under the Medi-Cal program.

Rationale for Recommendation
In order to assist the Board in determining next steps with the existing Development Agreement with the City of Orange, staff recommends engaging a real estate consultant.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. Board Action dated March 2, 2017, Consider Options for Development Rights at 505 City Parkway West, Orange, California Site
    a. Amended and Restated Development Agreement dated December 10, 2014
2. Notice of Request for Information #17-031, dated March 20, 2017, Amendment No. 1, for Property and Associated Real Estate Development Rights
3. Response to Request for Information: Property and Associated Real Estate Development Rights, TrammellCrowCompany, dated April 21, 2017
4. California Welfare and Institutions Code section 14087.54

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Options for Development Rights at 505 City Parkway West, Orange, California Site

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

Recommended Action
Authorize the Chief Executive Officer (CEO) to issue a Request for Information (RFI) to solicit responses regarding potential interest and options for CalOptima's development rights with results to be presented to the Board at a future date.

Background
At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the "605 Building Site." At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the Board authorized the CEO to enter into an Amended and Restated Development Agreement with the City of Orange to extend CalOptima's development rights for up to six additional years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At its August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

At the December 1, 2016 meeting, the Board authorized a contract amendment with real estate consultant, Newport Real Estate Services (NRES), to include site plan development and expenditures from existing reserves of up to $7,000 to fund the contract amendment.

Discussion
At its February 16, 2017 meeting, the Board of Directors' Finance and Audit Committee (FAC) received presentations from CalOptima management and real estate consultant, NRES. The presentation included an update on CalOptima's staffing needs and space alternatives, a review of a site plan developed by NRES, options for exercising the development rights with pros and cons of

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certain options, and a preliminary timeline. In addition, FAC members discussed the need to gather more information and to gauge potential interest on the following options: Direct Sale, Ground Lease, Joint Venture, and Property Trade.

An additional option is pursuing an extension of the current Development Agreement for an additional 3 years beyond 2020. This option would require approval by the City of Orange, and would likely require CalOptima to make additional public benefit fee payments. In the event the Board elects to pursue this option, and the City of Orange is agreeable to the extension, Staff will return to the Board to present applicable proposals.

Fiscal Impact
The recommended action to issue an RFI for development rights is budget neutral.

Rationale for Recommendation
The Development Agreement with the City of Orange provides CalOptima the opportunity to provide for future space needs in the event CalOptima requires additional office space. At the same time, the development rights are a valuable asset that can be severed from the existing parcel if CalOptima finds that CalOptima's construction of a separate office building and parking structure is not practical, feasible, or otherwise in the best interest of the organization. Management recommends that the Board authorize the CEO to issue an RFI to fully explore potential interest and options available with the existing development rights.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation
2. CalOptima Board Action dated December 1, 2016, Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan
3. NRES PowerPoint Presentation to the Board of Directors' Finance and Audit Committee dated February 16, 2017: Long-Range Strategic Real Estate Plan – Excess Real Estate Development or Disposition Update

/s/ Michael Schrader — *2/23/2017*
Authorized Signature — **Date**

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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

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background

In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

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Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

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Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

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Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder

NO FEE

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(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

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Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

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Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

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(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

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(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

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Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq*., all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

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Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

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Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

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23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

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IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

chief clerk for

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By:

Wayne W. Winthers, City Attorney

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DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

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ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

Suzanne M. Turf
Notary Public in and for said State

(SEAL)

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies),~~ and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

Michele E. Day
Notary Public in and for said State

(SEAL)

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EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

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EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

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RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

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widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

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EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the amendment of CalOptima's contract with real estate consultant Newport Real Estate Services to include site plan development; and
2. Appropriate expenditures from existing reserves of up to $7,000 to provide funding for this contract amendment.

Background

At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the CalOptima Board of Directors authorized the CEO to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At the August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

Discussion

Site Plan Development

Pursuant to the Board action on August, 4, 2016, CalOptima contracted with real estate consultant, Newport Real Estate Services, to provide market research, evaluate development feasibility and financial feasibility, and recommend options based on CalOptima's development rights. To move forward in exploring options related to the development rights, the consultant has recommended the

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development of a site plan to further inform the Board of potential opportunities. The projected cost to develop a site plan is $7,000.

Update from the Finance and Audit Committee (FAC)
At the November 17, 2016, meeting, the FAC received presentations from Management and real estate consultant, Newport Real Estate Services. Committee members requested Staff return to the FAC with additional information on the development rights at the next FAC meeting on February 16, 2017. Tentatively, Staff anticipates the FAC's recommendation will be put forward for the full Board's consideration at the March 2, 2017, meeting.

Fiscal Impact
The recommended action to fund the contract with a real estate consultant to develop a site plan is an unbudgeted item. An allocation of $7,000 from existing reserves will fund this action.

Rationale for Recommendation
Management anticipates that CalOptima's space needs will continue to grow in the near term. To accommodate this growth, management recommends that the Board authorize the CEO to fully explore options available with the existing development rights and to ensure that CalOptima's space needs are adequately met in the future.

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

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LONG-RANGE STRATEGIC REAL ESTATE PLAN – EXCESS REAL ESTATE: DEVELOPMENT OR DISPOSITION - UPDATE

- FINANCE AND AUDIT COMMITTEE MEETING
- FEBRUARY 16, 2017
- GLEN ALLEN, PRESIDENT
- NEWPORT REAL ESTATE SERVICES, INC.

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Purpose of Presentation

- CalOptima Staffing Needs
- Review Site Plan
- Review Development Rights Options: Pros/Cons
- Review Development Rights Timeline
- CalOptima Development vs. 3rd Party Disposition

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Summary of Discussion

Needs Assessment

- Assumptions
- Conclusions

Real Estate Alternatives

- Develop CalOptima Property
- 3rd Party/Disposition Alternatives – With Rights to Occupy

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Needs Assessment - Assumptions

- Optimized Telecommuting
- Assumes Projected Programs
  - Cal-MediConnect
  - Medi-Cal
  - OneCare
  - PCC Program
  - ACA Related and Demographic-Trend Member Growth
- Recapture of all 505 Space
- 1 person/181 s.f. space allocation

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Current Space Projection

505 Building Available Seats	
On Site	749
Filled Seats	46
Sub-Total	**795**
Teleworker/Community	318
Total	**1,114**
Total Space Available	**1,025**
Filled Seats and Temp Help	(795)
Total Vacant Spaces	**257**
Pending Requests to Fill	(142)
Expected Employee Count for New Programs	(26)
Net Space Surplus (Shortfall)	**89**
10th Floor Space	85
Total Surplus (Shortfall)	**174**

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Space Alternatives

- Offsite Lease or Purchase
- Extensive Telecommuting
- Multiple Shifts
- Relocate to a Larger Building
- Develop Adjacent CalOptima Property

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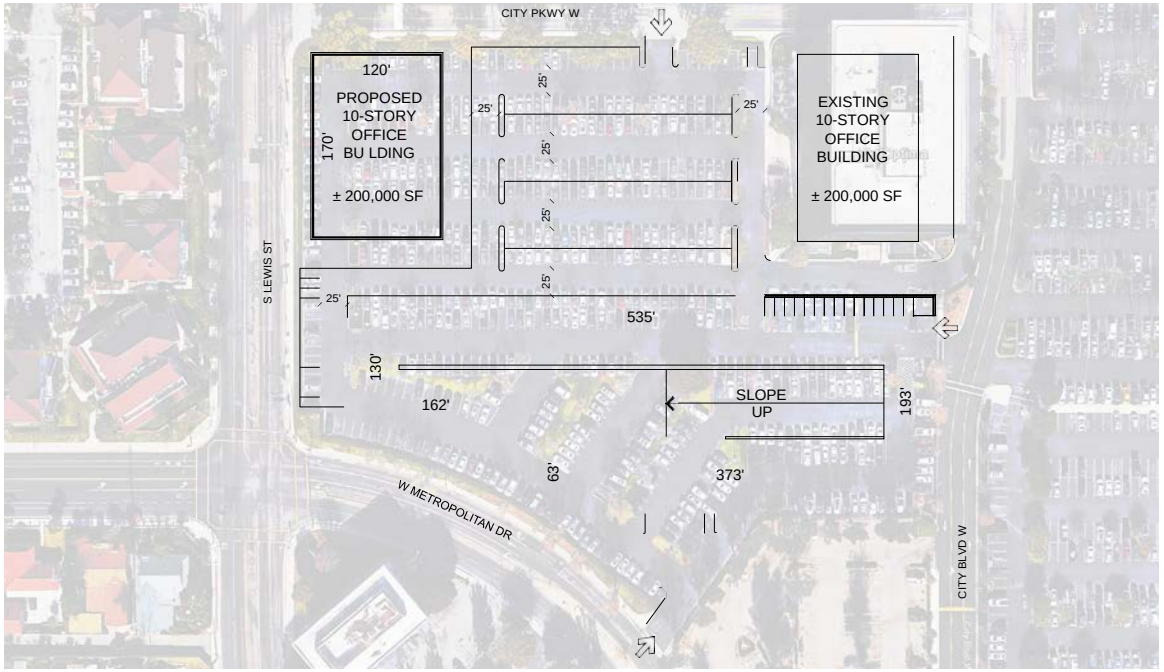
Site Plan



SITE PLAN

PROJECT DATA:

ZONING: UMU - URBAN MIXED USE

SITE AREA: ± 272J757 SF (±6.361 AC)

EXISTING BUILDING: 200,000 SF

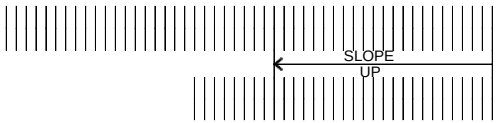
PROPOSED BUILDING: 200,000 SF

TOTAL BUILDING: 400,000 SF

F.A.R.: 1.46

PARKING REQUIRED: 2,000 STALLS
(400,000 SF @ 5/1000)

PARKING PROVIDED: ±2J032 STALLS
- SURFACE: 192 STALLS
- 1ST FLOOR STRUCTURE: 240 STALLS
- 2-6TH FLOOR STRUCTURE: 1,450 STALLS
  (290/STORY, TYP.)
- 7TH FLOOR: ±150 STALLS



TYPICAL PARKING LEVEL

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Development/Disposition Alternatives

RFI (To be Prepared)
- Direct Sale
- Ground Lease
- Joint Venture
- Trade of Nearby Property
  (Options to Occupy)

CalOptima Development/Construction
- Design/Bid/Build
- Design/Build
- Balance Sheet/Capital Implications
- Vacant Area Risk Assessment

Extend Development Agreement
- City Approval Required
- Fee Payment Likely Required

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Development Alternative Options

		Pros	Cons	Fiscal
Direct Sale:	**CalOptima could directly sell the development rights and secure space for CalOptima's use.**	**1. Large one time capital infusion 2. Reserved right for additional space 3. No development risk**	**1. Loss of future control 2. Restricted expansion rights 3. Lease payments required on additional space**	**1. Large, one-time capital event 2. No on-going income 3. Lease payments for additional space**
Ground Lease:	**CalOptima could lease the property to a developer.**	**1. Long-term income stream 2. Reserved right for additional space 3. No development risk**	**1. Loss of future control 2. Restricted expansive rights 3. Lease payments required on additional space**	**1. Long-term income stream with periodic adjustments 2. Lease payments for additional space**
Direct Development:	**CalOptima could assign the development rights to a developer, who would provide space back to CalOptima in return.**	**1. Property is already owned by CalOptima 2. Current Entitlement already in place 3. Multiple delivery/financing options 4. Total flexibility with building design 5. Future expansion space 6. Inclusion of PACE 7. Incorporation of formal board space 8. Eliminate need for offsite leased space**	**1. Time to delivery: 22-30 months 2. Splits staff to 2 buildings 3. Capital requirement**	**1. Large capital expenditures for development required 2. No future rent payments 3. No lease payment for additional space 4. Lease income from expansion space tenants**
Joint Venture:	**CalOptima could develop the property jointly with a developer.**	**1. Participation in development Upside 2. Reserved right for additional space 3. Reduced development risk**	**1. Participation in development Downside 2. Some cash flow and development risks 3. No cash flow during development and lease-up period 4. Consistency with CalOptima core mission 5. Market Risk**	**1. Variable on-going income from project cash flow 2. No large capital contribution required**
Exchange for Nearby Property:	**CalOptima could exchange the development rights for a developed property**	**1. Ability to obtain pre-built expansion space 2. Likely "built-in" phased space availability 3. On-going cash flow**	**1. Market Risk 2. Building operations obligations 3. Value of suitable trade property**	**1. No large capital outlay 2. On-going income stream**

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Conceptual Development Timeline

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CalOptima
Better Together

March 20, 2017

Amendment No.1
NOTICE OF REQUEST FOR INFORMATION (RFI)

#17-031

GENERAL CONDITIONS AND INSTRUCTIONS TO RESPONDENTS

For

PROPERTY AND ASSOCIATED REAL ESTATE DEVELOPMENT RIGHTS

Key RFI Dates

Written Questions Due: March 30, 2017, 12:00 p.m. Pacific Time
Proposal Submittal Date: April 21, 2017, 12:00 p.m. Pacific Time

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SECTION I: INSTRUCTIONS AND CONDITIONS

1. GENERAL INFORMATION

1.1. The purpose of this Request for Information (RFI) is to seek background information from qualified real estate developers regarding their interest in a potential real estate agreement with regard to CalOptima's Real Estate Development rights located at 605 City Parkway West, Orange, CA 92868.

1.2. THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued solely for information and planning purposes to assist CalOptima in finalizing the scope of work and requirements which may be used at a future date in the issuance of a Request for Proposal (RFP). It does not constitute a Request for Proposal (RFP) or a promise to issue an RFP in the future. This request for information does not commit CalOptima to contract for disposition whatsoever. Further, CalOptima is not at this time seeking proposals and will not accept unsolicited proposals. Respondents are advised that CalOptima will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future RFP. If a solicitation is released, it will be released through BidSync. It is the responsibility of the potential Respondent to monitor this site for additional information pertaining to this requirement.

2. POINT OF CONTACT

All communications relating to this RFI must be directed to CalOptima's designated contact below:

Kim Marquez
Senior Buyer
CalOptima Vendor Management Department
Kmarquez2@CalOptima.org

3. QUESTIONS AND CLARIFICATIONS

3.1. If a Respondent desires an explanation or clarification of any kind regarding any provision of this RFI, the Respondent must generate a written request for such explanation or clarification through BidSync by March 30, 2017, 12:00 p.m. Pacific time.

3.2. Inquiries received after March 30, 2017 12:00 p.m. Pacific time will not be responded to. Inquiries received by email to the contact above will not be responded to. All questions should be directed to CalOptima through BidSync.

3.3. CalOptima responses to questions will be communicated via BidSync, and will be sent no later than April 5, 5:00 p.m. Pacific time.

4. RESPONSES

Interested parties are requested to submit their response through BidSync no later than April 21, 2017, 12:00 p.m. Pacific Time. Information submitted outside of Bidsync will not be considered.

5. USE OF RESPONDENT'S RESONSE AND ACCOMPANYING MATERIAL

5.1. All materials submitted become the property of CalOptima and will not be returned. If the Respondent intends to submit confidential or proprietary information as part of its response, any limits on the use or distribution of that material should be clearly delineated in writing. However, CalOptima is a public agency and therefore subject to the California Public Records Act (California Government Code, Section 6250 et seq).

5.2. CalOptima will use reasonable precautions allowed by law to avoid disclosure of the Respondent response. CalOptima reserves the unrestricted right to copy and disseminate the Respondents response for internal review and for review by external advisors, at CalOptima's sole discretion.

6. INDUSTRY DISCUSSIONS

CalOptima representatives may or may not choose to meet with Respondents. Such discussions would only be intended to get further clarification of potential capability to meet the requirements.

7. SUMMARY

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY to identify available opportunities in the market as well as resources that can provide information regarding the CalOptima Real Estate Development rights. The information provided in the RFI is subject to change and is not binding on CalOptima. CalOptima has not made a commitment to contract for any of the items discussed, and release of this RFI should not be construed as such a commitment. All submissions become CalOptima property and will not be returned.

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SECTION II: CALOPTIMA BACKGROUND AND OVERVIEW

1. County Organized Health Systems (COHS) Background

The California State Medicaid (Medi-Cal) program came into existence in March 1966 as a fee-for-service health care delivery system. In May 1972, Medi-Cal beneficiaries began enrolling in managed care plans when the first Prepaid Health Plan (PHP) contract went into effect. Joining a PHP was voluntary and limited to those in a public assistance aid category.

In June 1983, a new type of managed care program, the County Organized Health System (COHS), became operational. The COHS managed care model ensures Med-Cal recipients access to comprehensive, cost-effective health care. Each COHS plan is sanctioned by the County Board of Supervisors and governed by an independent commission.

2. CalOptima Overview

CalOptima's Overview can be located by clicking on the following link and by selecting 'View CalOptima Fast Facts": https://www.caloptima.org/AboutUs.aspx

SECTION III: GENERAL REQUIREMENTS

1. BUSINESS OBJECTIVES/TIMING

CalOptima is considering monetizing the additional available land and entitlement rights located adjacent to its headquarters building located at 505 City Parkway West, Orange, California. CalOptima has the following key objectives:

1.1. Monetizing this asset while the development rights are still available;

1.2. Providing for potential additional expansion space to meet CalOptima's chartered goals and objectives.

While CalOptima has the ability and resources to develop the parcel internally, there may be significant advantages to having this development be completed through a sale (with leaseback opportunities), joint venture or other financial structure with a third-party.

The primary objective of this RFI is to begin to collect information on third parties that may be potentially interested in acquiring, joint venturing, trading or otherwise assist CalOptima in monetizing this asset.

While no particular timeframe has been established, the initial goal would be to enter into an agreement with a third-party that would allow for the development and construction of the building before expiration of the development rights in October, 2020.

As one of CalOptima's stated goals is to provide for the potential expansion of its workforce in furtherance of its core mission, and development rights for an additional office building are currently in place, CalOptima will only consider expressions of interest, and ultimately development of a class A office building of a type that is similar in quality and configuration to its existing 505 Building. Parties interested in land-use conversion (i.e. apartments or high density residential) should not respond to this RFI, as any such proposed uses will be dismissed without comment.

2. PROJECT OVERVIEW/BACKGROUND

CalOptima acquired the real estate development rights in 2014. The original development of the property site contemplated future construction of an additional 10 story 200,000 SF building to be known as 605 City Parkway West, Orange, CA, as well as an adjacent parking structure, which would accommodate both 505 and 605 buildings.

The objective of this RFI is to collect information from potential interested parties that might help CalOptima achieve these goals.

CalOptima is willing to consider a variety of potential real estate transaction structures. Responders are encouraged to address each of the alternatives outlined below. CalOptima does not, at this time, have a preferred structure. CalOptima will evaluate each of the responses in the interest of obtaining the greatest economic and intrinsic benefit to CalOptima. Respondents are also encouraged to propose alternative ideas that may be of interest to CalOptima.

CalOptima predicts that it may need additional space beyond its corporate headquarters, over time. As such, a continuing right, but not the obligation, to occupy space in the future building to be constructed by Offeror on the Excess Land may be of significant interest to CalOptima.

3. Considerations

3.1. Direct Fee Purchase: CalOptima may consider a direct fee purchase of the Excess Land and associated entitlements. Respondent's proposal for this approach must include estimates of

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proposed purchase price, transaction timing, and other general provisions of Respondent's proposal.

3.2. Ground Lease/Participating Ground Lease: CalOptima may consider a ground lease of the Excess Land. In the case of a ground lease, or participating ground lease proposal, the Offeror should include an estimated initial base rent, lease term and lease payment commencement, proposed escalation, ground lease term, subordination (an unsubordinated ground lease is strongly preferred), and other general terms of the ground lease/participating ground lease. In the event Offeror proposes a participating ground lease, Offeror's proposal should include minimum rent, percentage participating, formula and basis for participation as well as the other terms addressed in the fixed ground lease proposal.

3.3. Joint Venture: While a joint venture between a private-sector entity and a public agency does present its challenges, CalOptima wants to remain flexible with regard to potential transaction structures that may enhance cash flow, flexibility and overall economic benefit for the agency. Respondents proposing a joint venture structure should address joint venture structure preferential rates of return, capital contribution values, distribution priorities and capital risk exposure. Please keep in mind that CalOptima will require that its equity value be in first priority and not subject to foreclosure risk.

3.4. Potential Trade: As part of its mandated healthcare delivery mission for the residents of Orange County, CalOptima anticipates that its staffing levels may continue to increase over the coming years. While CalOptima does not occupy all of the current building, it anticipates that as a space in the building is recaptured, its space needs may exceed the capacity of the current building. As such, acquisition of a nearby, preferably, adjacent building may be of interest to CalOptima. Respondents that currently own a nearby building may want to consider proposing a trade of the Excess Land for such a building. Respondents considering this approach should address: the location and physical condition of the trade property, any existing leases or other restrictions on occupancy, building condition, and terms of trade.

4. Highlights of CalOptima's Development Rights Agreement

4.1. Development Agreement

a. Rights for development of the "605 Building" and related parking structure. Development rights for the referenced City Plaza Two Site were subsequently assigned to another developer (see Estoppel Certificate).

b. Section 1(j)(2)(B) - CUP for 605 Building site (approved by City Council 10/9/01) – 10 story, 200,000 SF building and a 5-level, 1,528 space parking structure.

c. Section 1(j)(3)-(6) – Cost sharing with other projects for area traffic improvements and widening of Orangewood Avenue bridge over the Santa Ana River (should be no exposure to such costs if development does not occur at the 605 Building site).

d. Section 7(e) – Good Faith Efforts Regarding Block of Orange Expansion – Mentions CC&R's of "The City" (to be further researched).

e. Section 12 – Term expires 10/28/19.

f. Section 14(a) – Covers assignment for a portion of the project sold; requires 30 day notification by Seller and Purchaser is to agree in writing to be subject to terms of the Agreement.

g. Section 14(b) – Reference is made to responsibility for reporting and annual review requirements (to clarify).

h. Public Benefit Fees. Fees would have needed to be paid in order to keep the Agreement active, including library and park related fees.

a. Prior to obtaining a certificate of occupancy, separate $25,000 fees would be required for two City of Orange Foundations.

4.2. First Amendment to Development Agreement – Executed 1/20/06:

a. Public Benefit Fees Payable - $15,000 of a $100,000 Park Fee to be paid within two business days of receiving a building permit for the 605 Building.

4.3. Second Amendment to Development Agreement

a. Amended Exhibit D is provided for, with remaining applicable fees being as follows

1. $15,000 Library Fee (15% of $100,000) and $15,000 Park Fee (15% of $100,000) within two business days of receiving a building permit for the 605 Building.

2. If the Agreement has not been terminated and an agreement has not been reached with the Block owner regarding certain elements of the proposed Block expansion, prior to obtaining a certificate of occupancy, separate $25,000 fees would be required for two City of Orange Foundations; and

3. Commencing on the Second Resolution Effective Date (5/30/07) and each anniversary thereof, continuing through the initial term (10/28/14), a $30,000 fee is required.

4.4. Operating Memorandum – Executed 1/22/07:

a. Block expansion plans were modified and CC&R's were amended by Block ownership and the City Parkway ownership at the time.

b. City Parkway owner relieved of any or all of the Public Benefit Fees.

4.5. Estoppel Certificate – Provided by City of Orange to the Current Ownership, 5/13/09:

a. Indicates Maguire assigned its rights to the City Plaza Two Site in August 2008 to HFOP City Plaza, LLC.

b. Acknowledges there were no Public Benefit Fees or other development, traffic mitigation or processing fees due from Maguire (seller) at that time.

c. Certificate shall inure to the benefit of Purchaser, Lender and their respective successors and assigns.

4.6. Conditional Use Permit – Resolution No. PC 19-01 (as referenced in Section 1(j)(2)(B) of the Development Agreement):

a. Approval for a 10-story, 200,000 SF office building and 5-level, 1,528 space parking structure, subject to several conditions and mitigation measures outlined in the CUP.

5. SUGGESTED CONTENT OF RESPONSE

CalOptima is asking interested Respondents to submit a response containing, at a minimum, the following information.

5.1. General Respondents Information

a. Explain the reason for your firm's interest in possibility providing the services listed within this RFI.

b. Name and contact information of person we can contact if we have questions.

c. Brief history of your firm.

d. Brief description of past experience providing similar services.

5.2. Additional Questions

a. Provide any comments, observations or suggestions which may assist CalOptima in drafting a procurement solicitation.

b. Please provide a brief summary of how you might envision the transaction structures that your firm would propose.

c. If possible, please provide preliminary economic results of how you might see a transaction being structured.

d. Please provide a potential timeline for any of the structures that you believe might be appropriate for your firm.

e. Please outline the obligations that your firm would request of CalOptima as part of any transaction structure.

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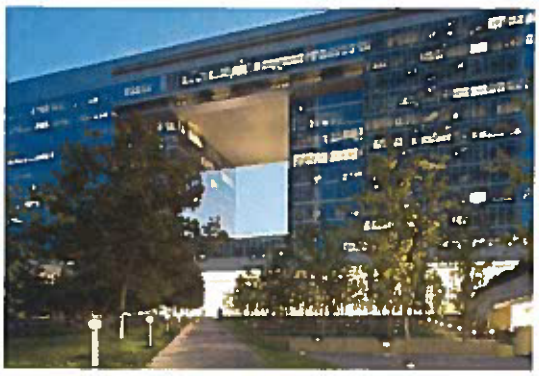
RESPONSE TO REQUEST FOR INFORMATION:

PROPERTY & ASSOCIATED REAL ESTATE DEVELOPMENT RIGHTS

605 CITY PARKWAY WEST, ORANGE, CA



PRESENTED TO:

CalOptima
A Public Agency
Better. Together.

PRESENTED BY:

Trammell Crow Company

APRIL 21, 2017

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Tom Bak
Senior Managing Director
Trammell Crow Company
Development and Investment

Trammell Crow Company

3501 Jamboree Road, Suite 230
Newport Beach, California 92660

Work: 949.477.4702
Fax: 949.477.9107

tbak@trammellcrow.com
www.trammellcrow.com

April 21, 2017

Ms. Kim Marquez
Senior Buyer
CalOptima Vendor Management Department
505 City Parkway West
Orange, CA 92868

RE: Response to RFI for Property & Associated Real Estate Development Rights at 605 City Parkway West

Dear Ms. Marquez:

We are pleased to formally provide this Response to Request for Information for the Property and Associated Real Estate Development Rights located at 605 City Parkway West in the City of Orange.

The Trammell Crow Company is widely recognized as the Nation's largest developer by total product under construction, and has been ranked #1 for the past three consecutive years in Commercial Property Executive Magazine's 2014, 2015, & 2016 list of national developers. The proposed team highlighted in this proposal offers local Class A Office Development experience backed by a nationally renowned organization.

In the pages that follow, you will find a detailed response that seeks to emphasize the following key elements that we believe position our team to provide CalOptima with the highest level of service and certainty of performance:

Local Presence & Experience: Trammell Crow Company has had a strong presence in Southern California since 1972. Our SoCal team is currently comprised of 28 real estate professionals who cover Orange County, Los Angeles, San Diego, and the Inland Empire. Over the last few years, while many of our competitors have disappeared, our balanced business model combining development with acquisitions has allowed us to thrive and gain substantial market share. Our Southern California team has experience building and entitling well over 100 projects across class "A" office, healthcare, industrial, retail, mixed use, and residential product types.

Office Development Expertise: Trammell Crow Company's Southern California Development & Investment team has an established reputation in Class-A office development, with individuals who dedicate their entire practice to the successful execution of office projects, specifically development and leasing. In just the past ten years, we have developed a diverse array of office product, including speculative, build-to-suit, ground-up and redevelopment, totaling 1.9M SF and valued at over $1.3 billion.

Public Agency & Government Collaboration: Our Team has a proven track record of successfully working with local governments on the acquisition, ground-leasing, development, planning, construction, leasing, and property management of office buildings leased to public agencies and governmental tenants. We are also experts in developing strategies for designing, financing and constructing projects that serve as sources of economic development for the surrounding community. These buildings are compelling places to work as well as sources of community identity and renewal.

Our team offers extensive Southern California development experience, a strong history of partnerships with governmental clients, design-build expertise, ability to independently finance the project, and, most importantly, a culture of honesty and dedication with a commitment to exceeding client expectations. We greatly appreciate your consideration and the opportunity to work with CalOptima on this exciting piece of property. We look forward to meeting with you to discuss our proposal. If you have any questions regarding the attached proposal, please do not hesitate to contact me.

Warm regards,

Tom Bak
Senior Managing Director

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PROPERTY & ASSOCIATED REAL ESTATE DEVELOPMENT RIGHTS

605 CITY PARKWAY WEST, ORANGE, CA

Trammell Crow Company

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SECTION 1. GENERAL RESPONDENTS INFORMATION

A. EXPLAIN THE REASON FOR YOUR FIRM'S INTEREST IN POSSIBILITY PROVIDING THE SERVICES LISTED WITHIN THIS RFI.

Since 1948, Trammell Crow Company (TCC) has consistently been viewed as a leader and innovator within the real estate development industry. The organization has built it's reputation by focusing on building the best product in the best location. Our Southern California Business Unit has been continually developing successful Class A office product on both a build-to-suit and speculative basis, throughout each of the past ten years, totaling the successful delivery and leasing of over 1.35M SF of office space since 2007, with another 550K SF on track to be completed later this year.

TCC has a long, successful reputation of development within Orange County, and is extremely bullish on this market. We are currently under construction on the largest speculative ground up office development in Southern California. As such, we are in contact with every tenant in the market that is looking for new, high quality work space. We view this as a tremendous opportunity to deliver Class-A office product to the Central County marketplace due to the asset's:

Premier Location: The subject property's premier location in the heart of the City of Orange, adjacent to existing Class A office product, and a surplus of amenities within walking distance makes this an ideal opportunity to provide the newest product to Central Orange County. TCC previously developed the Arena Corporate Center, a 385,000 SF nearby Class A office park, with significant success and has actively been searching for another opportunity in the sub-market.

In-Place Entitlements: The existing entitlements for the project offer a tremendous opportunity to deliver high quality space in a market that has seen minimal development in the past several years. Speed to market is essential in satisfying the needs of tenants in search of space.

We are confident that not only does this particular property offer tremendous potential to satisfy the needs of Orange County's tenant base, but TCC is the ideal group to strategically position, design, develop, and lease this excellent asset with a reputation of:

Successful Collaboration & Partnership with Public Agencies: TCC has worked with numerous governmental and public agencies to entitle, finance, design, and develop numerous Class-A projects throughout Southern California. As detailed in the following case studies, in the past 10 years alone, the TCC Southern California team has successfully completed five built-to-suit office projects, totaling approximately 600,000 SF, and is nearing start of construction on a 200,000 SF, highly customized Medical Office Building for the County of Riverside.

Consistent On-time & On-budget Deliveries: Whether CalOptima determines a need for additional space, or the entire building is ultimately marketed to the outside community, every tenant depends upon a reliable budget and schedule. TCC has a proven track record for delivering projects on-time and on-budget, resulting in consistent repeat business with our clients.

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B. Name and contact information of person we can contact if we have questions.

Profiles for the primary members of the development team that would be dedicated to this project are included on the following pages. David Nazaryk , Managing Director, will serve as Primary Point of Contact.

DEVELOPMENT TEAM

PROJECT DEVELOPMENTS

The Boardwalk
County Law Building
Gateway at Alhambra
Innovation Village Research Park
2000 Avenue of the Stars
Arena Corporate Centre
Pacific Vista
Kendall Healthcare BTS
Burbank Airport Plaza
Main Street District Center
California Palms Business Center
Sycamore Business Park
Knox Logistics Center
1-215 Logistics Center
Westec BTS
Centrepointe Chino I
Gateway Diamond Bar
Harman International Campus
Irwindale Business Center I
Irwindale Business Center II
Centrepointe Chino II

TOM BAK
SENIOR MANAGING DIRECTOR
3501 Jamboree Road, Suite 230
Newport Beach, California 92660
O: 949.477.4702
tbak@trammellcrow.com

Tom Bak is Senior Managing Director of Trammell Crow Company where he serves as a member of the firm's Operating Committee and as a subject matter expert for the National Investment Committee. In his capacity as Senior Managing Director, Tom is responsible for raising capital, setting investment strategy, creating deal flow, negotiating and structuring transactions, advising on financing, asset management and property-related issues, and overseeing the day to day activities of Trammell Crow's Southern California Development & Investment professionals.

EXPERIENCE

Under Tom's leadership, the Southern California Development & Investment Group has completed, or is in the process of completing, the acquisition and development of office, industrial and brownfield projects totaling over 20 million square feet and representing investments of over $1.5 billion from public and corporate pension funds, insurance companies, REITs, Taft Hartley funds, endowments and high net worth partners.

Tom began his career with Trammell Crow Company as a leasing agent. He has received numerous regional and national awards recognizing his achievements as a top leasing and development producer. In 1989, he became one of the youngest partners in the firm. In 1996, Tom became leader of the Southern California Development & Investment Group.

EDUCATION & CREDENTIALS

University of California Los Angeles, MBA
Amherst College, B.A.

PROFESSIONAL AFFILIATIONS/COMMUNITY INVOLVEMENT

Past President, National Association of Industrial and Office Properties (NAIOP) - Los Angeles Chapter
NAIOP I.CON Conference Speaker, Industrial Trends
University of California - Irvine, Center for Real Estate Advisory Board
Urban Land Institute Conference Speaker, Office Building Design Trends
Pension Real Estate Association (PREA), Developer Affinity Group
St. Joseph Hospital, Planning and Community Benefits Committees

DEVELOPMENT TEAM (PRIMARY POINT OF CONTACT)

PROJECT DEVELOPMENTS

The Boardwalk
County Law Building
Gateway at Alhambra
Innovation Village Research Park
2000 Avenue of the Stars
Arena Corporate Centre
Pacific Vista
Kendall Healthcare BTS
Westec BTS
Centrepointe Chino I
Gateway Diamond Bar
Harman International Campus
Irwindale Business Center I
Irwindale Business Center II
Centrepointe Chino II
Burbank Airport Plaza
Main Street District Center
California Palms Business Center
Sycamore Business Park
Innovation Village Research Park
Knox Logistics Center
I-215 Logistics Center

DAVID NAZARYK
MANAGING DIRECTOR
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Newport Beach, California 92660
O: 949.477.4732
DNAZARYK@TRAMMELLCROW.COM

David has developed much of TCC's portfolio in Southern California since joining the company in 1996. He also manages the operations of the group. He is responsible for sourcing, underwriting, financing and developing office and industrial projects throughout the Southern California region.

Through his relationships with the brokerage network, governmental officials and capital partners, David has seamlessly and successfully completed some of the largest and most complicated projects within the TCC national portfolio. He has structured and documented numerous development projects with TCC's existing investment relationships and has forged new ones for the company. He is also highly regarded in the company for his unique ability to craft and execute complicated built-to-suit projects. His reputation is one of over-delivering on his promise and providing maximum returns on a variety of real estate development projects. His efforts have been recognized locally and nationally by colleagues through NAIOP Best Project, San Gabriel Valley Best Developer and numerous other awards.

EXPERIENCE

Trammell Crow Company – Southern California– 1996 to Present
Managing Director

- Successfully master planned 10,600,000 SF and developed 6,000,000 SF of office and industrial projects throughout Southern California.
- Established land use designs and/or development plans through selecting, supervising and directing required consultants.
- Negotiates with cities and other governmental agencies to obtain appropriate development mix, entitlements, and land use design standards.
- Effectively markets specific projects such as land, speculative development or build-to-suit, for lease or sale.
- Coordinates all stages of off-site and on-site construction, including tentative and final parcel maps, infrastructure and utility drawings, street and utility construction, preliminary building site plans or office floor plans, working drawings, permit process, construction bidding, on-site shell and tenant improvement construction, Certificate of Occupancy and punch-list completion.
- Provides value engineering through construction experience and local consultant expertise.

Catellus Development Corporation – 1983 to 1996
Project Director

EDUCATION & CREDENTIALS

Evangel College, Springfield, MO, B.A., 1983

PROFESSIONAL AFFILIATIONS/COMMUNITY INVOLVEMENT

Board of Directors, American Red Cross
Member, National Association of Industrial and Office Properties
Member, Urban Land Institute

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DEVELOPMENT TEAM

MATT CRAMER
SENIOR VICE PRESIDENT
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O: 949.477.4735
mcramer@trammellcrow.com

Matt is a recognized industry leader in office product and often lends his expertise to other TCC business units. Matt's strengths include deal underwriting, securing of entitlements, comprehensive development management, pre-construction programming, design-build and construction management. His career path has included various positions from project superintendent to development manager and he is known for his ability to manage and execute difficult projects on time and on budget.

Matt brings more than 25 years of development and construction expertise to Trammell Crow Company. During his career, he has managed development and/or construction of over 9,000,000 square feet of office buildings, parking structures, mixed-use projects, industrial buildings, high tech facilities and public facilities, ranging from $5 million to over $300 million from conception to project completion. Matt is a recognized industry leader in office product and often lends his expertise to other TCC business units. Matt's strengths include deal underwriting, securing of entitlements, comprehensive development management, pre-construction programming, design-build and construction management. His career path has included various positions from project superintendent to development manager and he is known for his ability to manage and execute difficult projects on time and on budget.

PROJECT DEVELOPMENTS

The Boardwalk
County Law Building
Gateway at Alhambra
Innovation Village Research Park
Phase 3, 4, & 5
Washington Mutual Irvine
Office Expansion
Opus Center Irvine Phase I & II
Fairway Center II
Summit Phase I
Westec Orange County
Communications
Galaxy Latin America
Cabot, Cabot & Forbes
Corporate Center
South Coast Metro Center
I-215 Amazon BTS
Amazon Fulfillment Center
Redlands Business Park
Magnolia Point

EXPERIENCE

Trammell Crow Company – Newport Beach, CA – 2005 to Present
Senior Vice President, Development Management

Howard S. Wright Construction Company – 2003 to 2005
Project Executive/Business Unit Manager

Opus West Construction Corporation – 1998 to 2003
Senior Project Manager

L.E. Wentz Company – 1997 to 1998
Senior Project Manager

ARB, Inc. – 1995 to 1997
Project Manager

Turner Construction Company – 1987 to 1995
Project Superintendent

EDUCATION & CREDENTIALS

California State University, Long Beach, B.S., Construction Management

PROFESSIONAL AFFILIATIONS/COMMUNITY INVOLVEMENT

Member, NAIOP, SoCal and Inland Empire chapters
Advisory Council Member, California State University Long Beach School of Engineering
Member, Trammell Crow Company National LEED® "Green Task Force"
State of CA Registered Disaster Service Worker, OES Certified Safety Assessment Volunteer
Step Up On Second Charitable Organization, Past Chairman, Board of Directors

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DEVELOPMENT TEAM

PROJECT DEVELOPMENTS

The Boardwalk

County Law Building

Gateway at Alhambra

Ontario Innovation Center I & II

Knox Logistics Center

1-215 Logistics Center

Magnolia Point

Innovation Village 5

CHRIS TIPRE
SENIOR VICE PRESIDENT
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Newport Beach, California 92660
O: 949.477.4717
ctipre@trammellcrow.com

Chris serves as Senior Vice President for Trammell Crow Company's Southern California Business Unit in Newport Beach, California. He is responsible for land and deal sourcing, financial analysis, due diligence, entitlements, capital relationships, development coordination, and project marketing and leasing.

EXPERIENCE

Trammell Crow Company – Newport Beach, CA – 2011 to Present
Senior Vice President

- Responsible for management of finance, marketing, leasing, development and operations of 545K SF Class A speculative office development.
- Performs detailed and customized underwriting as primary analyst for all office and industrial acquisitions
- Prepares comprehensive investment summaries with asset and market level analyses for presentation to internal investment committee and institutional investment partners
- Works alongside capital partners, brokers, tenant representatives and prospective investors to analyze new opportunities

LBA Realty – Irvine, CA – 2011
Asset Management Intern

- Assisted in the valuation and management of a $4B portfolio of office and industrial assets

Terranomics Retail Services – Burlingame, CA – 2007 to 2008
Retail Commercial Real Estate Specialist

- Represented Fortune 500 and regional tenants to establish expansion plans, select locations, and negotiate leases in prime retail space
- Managed the leasing of over 2M SF of Power Centers and Grocery anchored shopping center space

Sotheby's International Realty – Santa Barbara, CA – 2006 to 2007
Residential Real Estate Agent

EDUCATION & CREDENTIALS

UC Irvine Merage School of Business, MBA, Real Estate & Finance
UC Santa Barbara, BA, Business & Economics with Emphasis in Accounting

PROFESSIONAL AFFILIATIONS & COMMUNITY INVOLVEMENT

NAIOP – SoCal Chapter
NAIOP – SoCal YPG Alumni
LEED® AP BD+C

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C. Brief History of your firm.

National Experience

Trammell Crow Company (TCC), founded in 1948 in Dallas, Texas, is one of the nation's leading developers and investors in real estate. The company has developed or acquired 2,600 buildings valued at $60 billion and over 565 million square feet. TCC's teams are dedicated to building value for its clients with professionals in 16 major cities throughout the United States. The company serves users of, and investors in office, industrial, retail, healthcare, multi-family residential, mixed use projects, higher education, and airport facilities. For those who occupy real estate, TCC can execute the development or acquisition of facilities tailored to meet its clients' needs. For investor clients, the company specializes in joint venture speculative development, acquisition/re-development ventures, build-to-suit development or providing incentive-based fee development services.

TCC is an independently operated subsidiary of CBRE Group, Inc. (NYSE:CBG), a publicly traded, Fortune 500 and S&P 500 company headquartered in Los Angeles, California. CBRE is the world's largest commercial real estate services and investment firm (in terms of 2016 revenue). For more information visit www.TrammellCrow.com.

Local Expertise

Since TCC's Southern California Development and Investment Group (SoCal D&I) opened in 1972, our team has developed over 100 office, industrial, retail, healthcare, and mixed use projects totaling more than 35 million square feet throughout Los Angeles, Orange, San Bernardino, Riverside, San Joaquin and San Diego Counties. Our Southern California team of 28 professionals is consistently ranked as a "Top Tier" developer and is known for consistently creating the right product in the right market.

Over the past fifteen years, SoCal D&I has built, or is in the process of building, 45 projects comprised of 115 buildings, totaling more than 18 million square feet of office, retail, and industrial product on nearly 1,000 acres of land with costs eclipsing $2.0 Billion. Our team includes in-house environmental expertise through EASI, a division dedicated to managing and mitigating environmental impacts and risks on all new developments. We have worked with numerous cities and municipalities throughout California including, but not limited to Alhambra, Anaheim, Century City, Corona, County of Riverside, Diamond Bar, Fontana, Indio, Irvine, Irwindale, Lake Forest, Los Angeles, Moreno Valley, Pasadena, Redlands, Riverside, and Tracy. Our Team has a proven track record of land acquisitions, ground-leasing, development, planning, construction, leasing, and property management of office buildings. Our experience in each of these areas is demonstrated by the projects outlined herein.

ONE OF THE NATION'S LEADING DEVELOPERS AND INVESTORS IN COMMERCIAL REAL ESTATE

TCC DEVELOPMENT

As of 4Q 2016

Development in Process	$6.5B
Pipeline	$4.1B
Operating	$0.2B
TOTAL	$10.8B

MERITS

#1 Top Development Firm Commercial Property Executive National 2014, 2015 & 2016

#1 Development Company 2014 & 2015
Modern Healthcare Magazine's Design and Construction Survey

$2.6B in construction starts in 2016

D. Brief description of past experience providing similar services.

The following case studies highlight the TCC SoCal Business Unit's range of experience and expertise across a range of office development product, including speculative, build-to-suit, ground up, and redevelopment.

COUNTY LAW BUILDING - INDIO, CA

PROJECT:	**COUNTY LAW BUILDING**
LOCATION:	Indio, CA
COMPLETION DATE:	December 2014, On Time and Under Budget
REFERENCE:	Stephen Gilbert, Development Manager, Riverside County EDA, (951) 955-4824
PROJECT TYPE:	Class A Office, Governmental Agency Build-to-Suit
SQUARE FOOTAGE:	90,000 SF
PROJECT SUMMARY:	In November 2012, Trammell Crow Company's Southern California Business Unit was selected by the County of Riverside Economic Development Agency as Developer to design, entitle, and construct a state of the art County Law Building in the City of Indio, CA. The new building consolidated multiple County legal departments into a single facility adjacent to the Larsen Courthouse. Located at the prominent corner of Highway 111 and Jackson Street, the Class-A, three story structure creates a focal point at the justice center complex in the midst of its revitalization. The 90,000 SF steel frame building takes advantage of a uniquely shaped site, addressing security and offering multiple access points to separate the public from employee and security oriented vehicle traffic. The building program resulted in the Family Justice Center and the Victim Witness functions occupying 55,000 SF, the Public Defender occupying 24,500 SF, the County Counsel 1,400 SF and the County Law Library 9,450 SF. A future freestanding 5,000 SF retail building will serve the law building and the adjacent community. The project is designed to provide a variety of passive people places both inside and out, including a generous entry plaza complete with an attractive water feature and public art sculpture, shaded outdoor seating and generously landscaped spaces. Through strategic planning, the design team was able to introduce multiple sustainable features including extensive sun shading devices, drought tolerant landscaping, on-site storm drain water retention while recharging the local ground water system, electric vehicle charging stations, photovoltaic parking shade structures, recycled content, low-emitting building materials and many other solutions that have resulted in the project receiving a LEED® Platinum Certification. The project was delivered ahead of schedule and $4M under budget.

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GATEWAY AT ALHAMBRA - ALHAMBRA, CA

PROJECT:	**GATEWAY AT ALHAMBRA**
LOCATION:	Alhambra, CA
COMPLETION DATE:	September 2012, On Time and Under Budget
REFERENCE:	Jeffrey Siebens, Assistant Director Construction Management, Community Development Commission, County of Los Angeles (626) 586-1792
PROJECT TYPE:	Class A Office, Redevelopment, Governmental Agency Build-to-Suit
SQUARE FOOTAGE:	118,265 SF

PROJECT SUMMARY:

In August 2010, the Trammell Crow Company's Southern California Business Unit was selected by the National Development Council and the Community Development Commission of the County of Los Angeles (LACDC) as the Developer to design, entitle and construct a state of the art office building for the LACDC. The Gateway at Alhambra was developed in an urban area, where the supply of land is severely constrained. The project development required the demolition of an existing theatre and renovation of an existing parking structure. By selecting a site that could utilize an existing structure, the project was guaranteed sufficient parking, and benefitted from decreased construction time and costs.

The Build-to-Suit office building consolidated two County entities, The Community Development Commission and the Housing Authority, previously located in three separate facilities into a single location. A requirement of the project was to integrate three different and distinct user groups into one building environment. As a redevelopment with an existing parking structure, the building ended up occupying nearly the entirety of the remaining site and the resulting space planning was integrated into a non-typical building site plan.

As a result of extremely efficient design and a collaborative space planning effort by all project constituents, TCC and the project architect were able to reduce the County's original space requirement from 155K SF down to 118K SF, a reduction of nearly 20%, resulting in a significant overall savings in project costs. As part of the project requirements the Community Development Commission required a LEED Silver certification level from the USGBC with the goal of developing a highly sustainable project that would conserve energy, water and non-renewable natural resources while creating a healthier and more comfortable work environment for the Commission and Housing Authority employees. Through strategic planning, the project far exceeded the Community Development Commissions goals as the project ultimately achieved LEED Gold certification.

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USC HEALTH SCIENCES BUILDING - LOS ANGELES, CA

PROJECT:	**USC HEALTH SCIENCES BUILDING**
LOCATION:	Los Angeles, CA
COMPLETION DATE:	August 2011, On Time and Under Budget
REFERENCE:	Kristina Raspe, Director, Real Estate and Facilities - Apple, (408) 862-7099
PROJECT TYPE:	Class A Office, Institutional Build-to-Suit
SQUARE FOOTAGE:	120,000 SF
PROJECT SUMMARY:	Trammell Crow Company was selected by the University of Southern California, from a pool of 17 development teams, to ground lease a 5.3 acre property adjacent to the University's Health Science Campus in downtown Los Angeles, create a financing structure to execute the project, and then develop a 120,000 SF administrative office building, which USC would lease back on a concurrent 20 year lease term. To provide USC with a turnkey building, Trammell Crow Company stepped in to manage the programming, design and layout, construction and FF&E delivery of the administrative office, classroom, fitness center and café space. This entailed consolidating 13 different users from all over the USC Los Angeles portfolio into a singular building, while maintaining the specific academic needs of each user group. The project was a resounding success, opening its doors on August 2011 to an onslaught of incoming students ready for their first day of the school year. The project was 4.5 months ahead of USC's required schedule and $2M under budget..

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INNOVATION VILLAGE RESEARCH PARK - POMONA, CA

PROJECT:	**INNOVATION VILLAGE RESEARCH PARK AT CAL POLY POMONA**
LOCATION:	Pomona, CA
COMPLETION DATE:	2007, June 2011, December 2015, On Time and Under Budget
REFERENCE:	Sandra Vaughan-Acton, Director of RE Development, Cal Poly Pomona Foundation, Inc. (909) 869-3154
PROJECT TYPE:	Master Planned Class A Office Park, Speculative & Build-to-Suit
SQUARE FOOTAGE:	369,000 SF
PROJECT SUMMARY:	Trammell Crow Company and Cal Poly Pomona University entered into a public/private venture to create a Research Park on its campus. The mission of the partnership was to create an environment in which the business community and the University could interact and collaborate with one another by offering internships to students, job opportunities for graduating students, support of campus programs, etc. TCC and Cal Poly worked together to refine a Master Plan for the remaining 65 acre master planned development with the goal of utilizing additional development opportunities for Build-to-Suits, on-campus academic and student housing facilities. Early in the process it was determined that modern 3-story tilt-up concrete buildings would be the most cost effective construction solution for the product type that was identified to meet the demand in the marketplace. Efficient 40,000 SF floor plates containing a core for each floor with two elevators and adequate restrooms offered flexibility for a wide variety of users, including corporate headquarters, back office, and multi-tenant spaces. The work environment was enhanced by the inclusion of lush landscaping, large people places for relaxation, lunches and outdoor work space, as well as extensive sustainable design features for energy savings, renewable energy, recycled materials, drought tolerant landscaping and water retention resulting in recharging the local groundwater system. Innovation Village Phase 3 commenced as a speculative development by TCC, however Southern California Edison (SCE) was soon identified as a tenant for the entire building. During Phase 3, TCC developed a close partnership with SCE, leading to additional Build-to-Suit opportunities at Innovation Village. In 2009 and again in 2014, TCC was selected as the Developer to design, entitle, and construct Phase 4 and Phase 5 as additional state-of-the-art office buildings to house SCE's Transmission Business Unit.

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ARENA CORPORATE CENTER - ANAHEIM, CA

PROJECT:	**ARENA CORPORATE CENTER**
LOCATION:	Anaheim, CA
COMPLETION DATE:	2003, On Time and Under Budget
PROJECT TYPE:	Speculative Class A Office Park
SQUARE FOOTAGE:	385,000 SF

PROJECT SUMMARY:

Arena Corporate Center is a prime example of how TCC's capabilities benefit our clients. Trammell Crow Company purchased 23 acres of land directly adjacent to the Arrowhead Pond in August 2001. The project, comprised of 3 two-story buildings totaling 385,000 square feet, was considered risky by industry experts due to rising vacancy rates, falling rental rates and the languishing recession.

The TCC team recognized that the submarket lacked quality back office space and determined the local tenant base would prefer a campus type environment, a product that was lacking in Central Orange County. Based on these findings, our team scrapped the existing entitled plans and designed 3 two-story buildings with the largest floor plates in the market. The project includes a one-acre palm tree courtyard with electrical and data hookups, outdoor jogging tracks, basketball court and on site showers. Tenants benefit from features such as 1,000 feet of visibility from the 57 freeway, traffic of almost 300,000 cars per day and 5:1 parking.

The project was an immediate success with Tenant Healthcare signing the first lease for 150,000 square feet prior to groundbreaking in March 2002. Construction was completed in June of 2003 and the project was 100% leased at above pro forma rents just 4 months later. Tenants include: Washington Mutual (56,210 SF), Advantage Sales (46,432 SF), Ameriquest (127,750 SF).

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THE BOARDWALK - IRVINE, CA

PROJECT:	**THE BOARDWALK**
LOCATION:	Irvine, CA
COMPLETION DATE:	Projected Completion Summer 2017, Currently On Time & On Budget
PROJECT TYPE:	Class A Speculative Office Campus
SQUARE FOOTAGE:	545,385 SF
PROJECT SUMMARY:	Located on Orange County's most traveled thoroughfare, this 7.5 acre project will be comprised of two, nine-story towers totaling approximately 545,000 square feet of best-in-class office space, two acres of landscaped outdoor space, and abundant on-site amenities. Designed by world renowned architect Gensler, The Boardwalk is poised to revolutionize the Orange County workplace through a perfect blend of form and function, delivering not only iconic architecture and a picturesque landscape, but a design that promotes productivity, efficiency, wellness, and a coastal lifestyle. The buildings offer large floor plates, connected on alternating floors with indoor bridges and outdoor terraces. By bridging the two buildings, The Boardwalk provides the opportunity for up to 65,000 square feet of contiguous space on a single floor, offering unmatched connectivity and efficiency, and office and amenity space unlike anything else in the market. This cutting edge design will enhance productivity by promoting collaboration and demonstrate a creative culture. The Boardwalk offers a comprehensive amenity package including indoor and outdoor workspace, on-site fitness and wellness center, and on-site dining options to provide a well-rounded lifestyle for its occupants. The project is currently under construction, with completion scheduled for Summer of 2017. Leasing is underway, with multiple leases and LOI's currently being negotiated with potential to account for over 400,000 SF of space.

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RIVERSIDE UNIVERSITY HEALTH SYSTEM MOB - MORENO VALLEY, CA

PROJECT: **RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL OFFICE BUILDING**

LOCATION: Moreno Valley, CA

COMPLETION DATE: Projected Completion 4Q 2019

PROJECT TYPE: Master Planned Development, Phase 1: Class A Build-to Suit Medical Office Building

SQUARE FOOTAGE: 200,000 SF

PROJECT SUMMARY: In April 2015, Trammell Crow Company's Southern California Business Unit was selected as the Master Developer and Owner to plan, design, entitle and construct a state of the art medical office building for the County of Riverside Economic Development Agency and the Riverside University Health System Medical Center. The new building would be located within the existing parking field of the Medical Center and would provide ambulatory care services and ancillary functions for the hospital.

TCC was requested to provide a 200,000 SF MOB located directly in front of the main entrance to the hospital from Cactus Avenue. The building was sited in a manner that allows for connectivity to the existing Education Building & parking fields, as well as future integration into the hospital campus and a proposed parking structure to the east. The location of the building required the re-location of the main entry drive further from the current southern location to the west and creating a new 8,000 SF Lobby/Café building with a connected canopy structure to bring visitors and patients in from the west side of the hospital. Services provided include multi-specialty clinics, outpatient surgery, and physical therapy programs.

After evaluating various financing structures, it was determined that the MOB would be constructed with funds secured through a Credit Tenant Lease (CTL). CTL loans are credit-based debt instruments that provide fully amortizing loans that are coterminous with a tenant's lease. This unique and extremely complex financing vehicle provides tenants with investment grade credit, the ability to finance the entire cost of a new facility through a "rent-to-own" structure. CTL financing offers options for both monetizing existing assets and capitalizing build to suits.

In April 2017, TCC successfully completed entitlements, finalized negotiations on the ground lease and facilities lease, and secured the CTL loan for the County of Riverside. Construction of the 200,000 SF MOB facility is slated to commence later this year, with completion projected for 4Q 2019.

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SECTION 2. ADDITIONAL QUESTIONS

A. PROVIDE ANY COMMENTS, OBSERVATIONS OR SUGGESTIONS WHICH MAY ASSIST CALOPTIMA IN DRAFTING A PROCUREMENT SOLICITATION.

TCC has vast experience working with numerous public agencies throughout the RFP and ultimately the development process. As a result, some of the fundamental elements that we have identified and recommend which will allow for the smoothest and most efficient procurement process include:

1. Provide a central point of contact for the decision making team. A clear line of communication will simplify and expedite the procurement and negotiation process.

2. Be prepared with a streamlined decision making process. As outlined below, the entire development process will take two or more years to complete. In order to capitalize on the in-place entitlements and current market demand, CalOptima and the new buyer will need to ready to move quickly and efficiently.

3. If possible, be prepared to further define CalOptima's future space requirements prior to issuance of the RFP. Quantifying the square footage required reduces risk by providing greater certainty for the developer and could expedite the overall development process.

4. Evaluate the overall quality of the developer as part of the offer. In addition to the basic terms of the proposal, CalOptima's consideration should include not only track record, experience, and capitalization, but also the reputation and culture. At a minimum, CalOptima will be neighboring the new building, and could potentially occupy space in the new project. As such, a collaborative buyer and potential partner will be a critical element in the next phase of the project.

B. PLEASE PROVIDE A BRIEF SUMMARY OF HOW YOU MIGHT ENVISION THE TRANSACTION STRUCTURES THAT YOUR FIRM WOULD PROPOSE.

As outlined in the above case studies, TCC has the capability to finance and develop premier office space under various deal structures and can offer a range of financing structures. Our team is equally well suited for traditional joint venture relationships with institutional capital partners, as well as collaborative partnerships with governmental and public agencies. We have substantial experience with and are open to various deal structures. While each arrangement is ultimately market driven, we focus on how we can assist and deliver results to our clients.

1. **Direct Fee Purchase: CalOptima may consider a direct fee purchase of the Excess Land and associated entitlements. Respondent's proposal for this approach must include estimates of proposed purchase price, transaction timing, and other general provisions of Respondent's proposal.**

   While TCC anticipates fair market value for the land and associated entitlements, additional aspects of the project would need to be further understood before pricing could be determined. TCC is highly interested and prepared to pursue this asset, but will require additional information relating to status of entitlements, CC&R's, off-sites, subdivision process, reciprocal parking agreements, exactions, and plan check and permit fees. Additionally, CalOptima's future requirements for space or options on space could have an impact on what would be determined to be fair market value.

2. **Ground Lease/Participating Ground Lease: CalOptima may consider a ground lease of the Excess Land. In the case of a ground lease, or participating ground lease proposal, the Offeror should include an estimated initial base rent, lease term and lease payment commencement, proposed escalation, ground lease term, subordination (an unsubordinated ground lease is strongly preferred), and other general terms of the ground lease/participating ground lease. In the event Offeror proposes a participating ground lease, Offeror's proposal should include minimum rent, percentage participating, formula and basis for participation as well as the other terms addressed in the fixed ground lease proposal.**

   While Trammell Crow Company's Newport Beach Business Unit has extensive experience with ground leases, it is not our preferred deal structure. However, we have a thorough understanding of the process, including the unique nuances of underwriting and structuring of ground lease documents. In the eyes of the ownership and investment community, the ground lease is generally considered to be an inferior structure to fee simple ownership. As such, the terms of the ground lease would need to reflect this discount in valuation.

Under a ground lease scenario, the rent or rate of return to CalOptima as the ground lessor will be largely dependent upon the requirement as a tenant. In order to appropriately propose pricing, TCC will need to further understand whether the existing building would be included, and if so, the physical condition and CalOptima's intended occupancy duration of the existing building, as well as any potential future space and timing needs within the new building.

3. **Joint Venture: While a joint venture between a private-sector entity and a public agency does present its challenges, CalOptima wants to remain flexible with regard to potential transaction structures that may enhance cash flow, flexibility and overall economic benefit for the agency. Respondents proposing a joint venture structure should address joint venture structure preferential rates of return, capital contribution values, distribution priorities and capital risk exposure. Please keep in mind that CalOptima will require that its equity value be in first priority and not subject to foreclosure risk.**

   TCC has completed Joint Ventures in various forms with public and governmental agencies, as well as traditional partnerships with institutional investors. In order to best structure an agreement with any partner, in depth conversations must take place in order to communicate, understand, and agree upon an overall investment strategy. In order to propose the most appropriate deal structure, TCC would request the opportunity to discuss CalOptima's appetite for risk, return expectations, equity and debt contributions, investment duration, and potential occupancy needs within the to-be-built building.

   By determining CalOptima's future needs, TCC can establish a clear and strategic go forward strategy that will maximize the value of the property, as well as provide or arrange for a variety of financing vehicles which will provide ultimate flexibility for both parties.

4. **Potential Trade: As part of its mandated healthcare delivery mission for the residents of Orange County, CalOptima anticipates that its staffing levels may continue to increase over the coming years. While CalOptima does not occupy all of the current building, it anticipates that as a space in the building is recaptured, its space needs may exceed the capacity of the current building. As such, acquisition of a nearby, preferably, adjacent building may be of interest to CalOptima. Respondents that currently own a nearby building may want to consider proposing a trade of the Excess Land for such a building. Respondents considering this approach should address: the location and physical condition of the trade property, any existing leases or other restrictions on occupancy, building condition, and terms of trade.**

   TCC is open to exploring trade opportunities following further discussion and understanding of CalOptima's needs and requirements.

C. If possible, please provide preliminary economic results of how you might see a transaction being structured.

As previously discussed, TCC is open to and will entertain various types of structures. However, returns will be predicated upon market forces, as well as a number of economic factors which will need to be further discussed as a partnership or buyer/seller relationship progresses. As a potential occupant of the to-be-built building, the needs of CalOptima will be a primary driver in how best to structure a deal and potential profitability. TCC brings substantial experience and expertise in the development process, as well as deal structure creativity and capital relationships which provide for ultimate flexibility in delivering a variety of finance vehicles, including traditional equity and debt joint ventures, tax exempt bond financing, Credit Tenant Leases (CTL), or synthetic leases, among others. TCC will be better suited to address profitability for both parties after assessing CalOptima's needs as both a tenant and investor.

D. Please provide a potential timeline for any of the structures that you believe might be appropriate for your firm.

Following the April 21st receipt of the RFI responses CalOptima will need to read, evaluate, and interview the respondents. By allowing 30 to 45 days for that process, TCC would estimate a June 2017 commencement and the following approximate timelines if an RFP was deemed necessary.

a) RFP – 60 to 90 days
b) PSA / JV document – 30 days
c) Escrow – 60 to 90 days
d) Design – 10 to 12 months
e) Construction – 14 to 18 months
f) Lease Up of non-CalOptima space – TBD subject to determining CalOptima expansion requirement – 0 to 24 months

E. Please outline the obligations that your firm would request of CalOptima as part of any transaction structure.

As a potential partner or purchaser of the property, TCC would request from CalOptima, the following obligation and information:

- Exclusive right to negotiate
- Further understanding of CalOptima's timing expectations for identifying future expansion needs
- Further understanding of CalOptima's preferred deal structure
- Further understanding of CalOptima's experience and history as both a Joint Venture Partner or Ground Lessor

TESTIMONIALS

Trammell Crow Company

amazon

"Trammell Crow Company's teamwork atmosphere and leadership in the development process has led to a highly successful project for all parties concerned."

"Trammell Crow Company is a great partner, and we look forward to continuing our relationship."

"Their expertise in development management and their knowledge of the university's and the state's approval process greatly aided the project team in successfully completing these two projects in a timely manner; allowing SCE to move personnel into the facilities ahead of all expectations. Their guidance and counsel to the project team was invaluable. All personnel associated with the project were both helpful and professional in all aspects."

SOUTHERN CALIFORNIA EDISON

An EDISON INTERNATIONAL Company

City of Alhambra

"Trammell Crow Company team leadership capabilities and knowledge of development has created an effective relationship with City Staff and a proactive approach to the development which has yielded an outstanding project that will enhance the City Central Business District for years to come. Trammell Crow Company continues to be a reliable partner, one that meets their obligations and commitments to the community."

"The Cal Poly Pomona Foundation highly recommends the Trammell Crow Company as a developer. We are very pleased to be partnering with them now, and we look forward to future partnerships."

Cal Poly Pomona Foundation

COUNTY OF LOS ANGELES CALIFORNIA

"The Community Development Commission of the County of Los Angeles wishes to express its appreciation to the Trammell Crow Company... "

"Trammell Crow Company's excellence as a developer is second to none. The firm meets its commitments."

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Trammell Crow Company

3501 Jamboree Road, Suite 230
Newport Beach, CA 92660
(949) 477-4700

www.trammellcrow.com

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State of California

WELFARE AND INSTITUTIONS CODE

Section 14087.54

14087.54. (a) Any county or counties may establish a special commission in order to meet the problems of the delivery of publicly assisted medical care in the county or counties and to demonstrate ways of promoting quality care and cost efficiency.

(b) (1) A county board of supervisors may, by ordinance, establish a commission to negotiate the exclusive contract specified in Section 14087.5 and to arrange for the provision of health care services provided pursuant to this chapter. The boards of supervisors of more than one county may also establish a single commission with the authority to negotiate an exclusive contract and to arrange for the provision of services in those counties. If a board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county by this article shall be vested in the county commission. Any reference in this article to "county" shall mean a commission established pursuant to this section.

(2) A commission operating pursuant to this section may also enter into contracts for the provision of health care services to persons who are eligible to receive medical benefits under any publicly supported program, if the commission and participating providers acting pursuant to subcontracts with the commission agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the commission does not ensure sufficient funding to cover program costs. The commission shall not use any payments or reserves from the Medi-Cal program for this purpose.

(3) In addition to the authority specified in paragraph (1), the board of supervisors may, by ordinance, authorize the commission established pursuant to this section to provide health care delivery systems for any or all of the following persons:

(A) Persons who are eligible to receive medical benefits under both Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(B) Persons who are eligible to receive medical benefits under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395).

(C) Other individuals or groups in the service area, including, but not limited to, public agencies, private businesses, and uninsured or indigent persons. The commission shall not use any payment or reserve from the Medi-Cal program for purposes of this subparagraph.

(4) Nothing in this section shall prohibit a commission established pursuant to this section from providing services pursuant to subparagraph (C) of paragraph (3) in counties other than the commission's county if the commission is approved by the Department of Managed Health Care to provide services in those counties. The

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commission shall not use any payment or reserve from the Medi-Cal program for purposes of this paragraph.

(5) For purposes of providing services to persons described in subparagraph (A) or (B) of paragraph (3), if the commission seeks a contract with the federal Centers for Medicare and Medicaid Services to provide Medicare services as a Medicare Advantage program, the commission shall first obtain a license under the Knox-Keene Health Care Service Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(6) With respect to the provision of services for persons described in subparagraph (A) or (B) of paragraph (3), the commission shall conform to applicable state licensing and freedom of choice requirements as directed by the federal Centers for Medicare and Medicaid Services.

(7) Any material, provided to a person described in subparagraph (A) or (B) of paragraph (3) who is dually eligible to receive medical benefits under both the Medi-Cal program and the Medicare Program, regarding the enrollment or availability of enrollment in Medicare services established by the commission shall include notice of all of the following information in the following format:

(A) Medi-Cal eligibility will not be lost or otherwise affected if the person does not enroll in the plan for Medicare benefits.

(B) The person is not required to enroll in the Medicare plan to be eligible for Medicare benefits.

(C) The person may have other choices for Medicare coverage and for further assistance may contact the federal Centers for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or www.Medicare.gov.

(D) The notice shall be in plain language, prominently displayed, and translated into any language other than English that the commission is required to use in communicating with Medi-Cal beneficiaries.

(c) It is the intent of the Legislature that if a county forms a commission pursuant to this section, the county shall, with respect to its medical facilities and programs occupy no greater or lesser status than any other health care provider in negotiating with the commission for contracts to provide health care services.

(d) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, the manner of appointment, selection, or removal of commissioners, and how long they shall serve, and any other matters as a board of supervisors deems necessary or convenient for the conduct of the county commission's activities. A commission so established shall be considered an entity separate from the county or counties, shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, and shall file the statement required by Section 53051 of the Government Code. The commission shall have in addition to the rights, powers, duties, privileges, and immunities previously conferred, the power to acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to enter into agreements under Chapter 5 (commencing with Section

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6500) of Division 7 of Title 1 of the Government Code. Any obligations of a commission, statutory, contractual, or otherwise, shall be the obligations solely of the commission and shall not be the obligations of the county or of the state.

(e) Upon creation, a commission may borrow from the county or counties, and the county or counties may lend the commission funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(f) In the event a commission may no longer function for the purposes for which it was established, at the time that the commission's then existing obligations have been satisfied or the commission's assets have been exhausted, the board or boards of supervisors may by ordinance terminate the commission.

(g) Prior to the termination of a commission, the board or boards of supervisors shall notify the State Department of Health Care Services of its intent to terminate the commission. The department shall conduct an audit of the commission's records within 30 days of the notification to determine the liabilities and assets of the commission. The department shall report its findings to the board or boards within 10 days of completion of the audit. The board or boards shall prepare a plan to liquidate or otherwise dispose of the assets of the commission and to pay the liabilities of the commission to the extent of the commission's assets, and present the plan to the department within 30 days upon receipt of these findings.

(h) Upon termination of a commission by the board or boards, the county or counties shall manage any remaining assets of the commission until superseded by a department approved plan. Any liabilities of the commission shall not become obligations of the county or counties upon either the termination of the commission or the liquidation or disposition of the commission's remaining assets.

(i) Any assets of a commission shall be disposed of pursuant to provisions contained in the contract entered into between the state and the commission pursuant to this article.

(j) Nothing in this section shall be construed to supersede Section 14093.06 or 14094.3.

(Amended by Stats. 2007, Ch. 483, Sec. 51. Effective January 1, 2008.)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Consider Approving Palliative Care Policy and Procedure (P&P) and Authorizing Execution of Agreement with the Department of Health Care Services to Fund the P&P's Implementation

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Tracy Hitzeman, RN, Executive Director, Clinical Operations, (714) 246-8400

Recommended Actions

1. Approve CalOptima's palliative care policy and procedure; and
2. Authorize and direct the Chairman of the CalOptima Board of Directors to execute a stand-alone agreement with the Department of Health Care Services (DHCS) to fund implementation of the palliative care policies and procedures.

Background

Senate Bill 1004 (Hernandez, Chapter 574, Statutes of 2014) requires the DHCS to "establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services." As palliative care is already a benefit, DHCS has indicated there will be no rate adjustment for managed Medi-Cal plans. CalOptima intends to compensate providers on a fee-for-service basis for services provided in the direct networks (CalOptima Community Network and CalOptima Direct) using the standard CalOptima contracting processes and fee schedule.

Several technical assistance meetings have been held by DHCS with managed care plans, providers and other stakeholders. In October 2017, APL 17-015 Palliative Care and Medi-Cal Managed Care was published. The APL provides managed care plans with direction to approve palliative care services when a beneficiary meets minimum general and disease-specific eligibility criteria, effective January 1, 2018.

On November 15, 2017, DHCS sent CalOptima a draft contract to allow DHCS to fund the development of CalOptima's Palliative Care policies and procedures as a one-time payment in the amount of $50,000. CalOptima staff developed these documents and forwarded them to DHCS for review. On November 15, 2017 DHCS approved this P&P.

Discussion

Palliative care is an approach to care delivery that emphasizes the needs of an individual to have relief of physical, mental and emotional symptoms that are distressing to the individual and their family and that decrease the member's quality of life. Active curative treatment may be sought by the member concurrently with palliative care.

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The American Board of Medical Specialties approved the designation of Palliative Care and Hospice as a sub-specialty in 2006 with 10 participating Member Boards. Palliative care services may be delivered in an acute/sub-acute hospital, a nursing facility, in the community, or in-home settings.

Many of CalOptima's Health Networks already have well-structured palliative care services program. Additional funding from the state will be used to implement the Palliative Care Policy and Procedures including outreach and education to practitioners, networks and other providers, oversight of delegated entities and data collection, analysis and submission to DHCS. CalOptima's implementation of APL 17-015 Palliative Care and Managed Medi-Cal will increase awareness of the palliative care, provide uniform reporting of the services, meet the requirements as outlined in SB 1004 and most importantly, increase member access to these services.

Numerous studies have demonstrated, and it is CalOptima's and DHCS' assumption, that palliative care can prevent inappropriate utilization of services. Using reporting processes that will be implemented pursuant to the attached policy, CalOptima will be able to better analyze palliative care services and its overall cost. We anticipate that the resulting data will affirm those assumptions.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2017-18 Operating Budget approved by the Board on June 1, 2017, included expenses related to palliative care services, as one component of overall medical costs. Due to the challenges associated with quantifying specific costs and savings, the budget did not include forecasts specific to palliative care services. However, staff believes the use of palliative care services for appropriate individuals are expected to result in an overall decrease to the cost of care or be budget neutral.

Rationale for Recommendation
The actions recommended will support ongoing and increased focus on addressing CalOptima members' relief of physical, mental and emotional symptoms, while allowing for continued access to curative care in the instances of significant illness. By addressing needs in a proactive, structured and consistent manner, the member will experience an improved quality of life and decreased incidence of uncontrolled symptoms that may lead to inappropriate ED visits, hospitalizations and other medical services. Additionally, the implementation of the policy and procedure will allow CalOptima to adhere to DHCS reporting requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
CalOptima Policy No. GG.1550, Palliative Care Services

/s/ Michael Schrader — *11/30/2017*
Authorized Signature — **Date**

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Policy #:	GG.1550
Title:	**Palliative Care Services**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2018
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy defines the scope of the Palliative Care program for CalOptima Medi-Cal Members.

II. POLICY

A. Effective January 1, 2018, CalOptima shall provide Palliative Care services to Members as outlined in this Policy, Senate Bill (SB) 1004 (2014) and Department of Health Care Services (DHCS) All Plan Letter 17-015: Palliative Care and Medi-Cal Managed Care.

B. CalOptima and its Health Networks shall have a network to ensure that Members have effective and appropriate access to Palliative Care services.

C. CalOptima or a Health Network shall coordinate Palliative Care services utilizing qualified providers, including but not limited to hospitals, long-term care facilities, community clinics, hospice agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in Palliative Care, and based on the setting and needs of the Member.

D. CalOptima or a Health Network shall provide Medically Necessary Palliative Care services to Members meeting all the following minimum eligibility requirements, including at least one (1) of the disease-specific eligibility criteria as described in Section II.E. of this Policy:

1. The Member is likely to or has started to use the hospital or emergency department to manage his or her advanced disease (unanticipated decompensation and not including elective procedures); and

2. The Member has an advanced illness as outlined in Section II.E. of this Policy with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment; and

3. The Member's death within a year would not be unexpected based on clinical status; and

4. The Member has either received appropriate patient desired medical therapy, or is a Member for whom Member-desired medical therapy is no longer effective. The Member is not in reversible decompensation; and

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5. The Member, and if applicable, the Member's family/Member-designated support person agrees to:

    a. Attempt, as medically/clinically appropriate, in-home, residential-based or outpatient disease management/palliative care prior to use of the emergency department, and

    b. Participate in Advance Care Planning discussions.

E. Disease-Specific Minimum Eligibility Criteria

1. Congestive Heart Failure (CHF) with both:

    a. New York Heart Association (NYHA) heart failure classification III or higher or is hospitalized due to CHF as a primary diagnosis with no further invasive interventions planned; and

    b. Has an ejection fraction less than 30 percent (30%) for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease (COPD)

    a. Forced Expiratory Volume (FEV) less than 35 percent (35%) of predicted and twenty-four (24)-hour oxygen requirement of less than three (3) liters per minute; or

    b. Twenty-four (24)-hour oxygen requirement of greater than or equal to three (3) liters per minute.

3. Advanced cancer with both:

    a. Stage III or IV solid organ cancer, lymphoma or leukemia; and

    b. A Karnofsky Performance Scale (KPS) score less than or equal to 70 or has failure of two (2) lines of standard of care therapy (chemotherapy or radiation therapy).

4. Liver disease with:

    a. Irreversible liver damage, serum albumin less than 3.0 and International Normalized Ration, (INR) greater than 1.3, and

    b. Ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or

    c. Evidence of irreversible liver damage and has a Model for End Stage Liver Disease, (MELD) score of greater than 19.

F. If a Member continues to meet the above minimum eligibility criteria as outlined in this Policy, he or she may continue to access both Palliative Care and Curative Care until the condition improves, stabilizes, or results in death.

G. Palliative Care services shall include the following services coordinated by the Provider:

1. Advanced Care Planning, including documented discussions between a physician or other qualified healthcare professional and a Member, family member, or legally recognized decision-maker. Counseling that occurs during these discussions shall address, but not be limited to, Advance Directives, such as Physician Orders for Life-Sustaining Treatment (POLST);

2. Palliative Care assessment and consultation, which may be provided at the same time as Advance Care Planning or in subsequent Member conversations to collect both routine medical data and additional personal information not regularly included in a medical history. During an initial and/or subsequent Palliative Care consultation or assessment, topics may include, but are not limited to:

    a. Treatment plans, including Palliative Care and Curative Care;

    b. Pain and medication side effects;

    c. Emotional and social challenges;

    d. Spiritual concerns;

    e. Member goals;

    f. Advance Directives, including POLST forms; and

    g. Legally-recognized decision maker.

3. Plan of care developed with the engagement of the Member and/or the Member's Authorized Representative. If a Member already has a plan of care, the Provider shall update the plan to reflect any changes resulting from the Palliative Care consultation or Advance Care Planning discussion. The Member's plan of care must include all authorized Palliative Care, including but not limited to pain and symptom management and Curative Care. The plan of care must not include services already received through another Medi-Cal-funded benefit program.

4. The Palliative Care team shall include a group of individuals who work together to meet the physical, medical, psychosocial, emotional and spiritual needs of the Member and the Member's family and are able to assist in identifying sources of pain and discomfort of the Member. This may include, but is not limited to, problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, and/or nausea. The Palliative Care team shall also address other issues such as medication services and allied health needs.

    a. The Palliative Care team may include, but is not limited to, the Member's Primary Care Provider (PCP), a registered nurse, licensed vocational nurse or nurse practitioner, and a social worker. Chaplain services may be part of the Palliative Care team.

    b. The Palliative care team members shall provide all authorized Palliative Care services.

5. Care coordination provided by a member of the Palliative Care team, to ensure continuous assessment of the Member's needs and to implement the plan of care.

6. Pain and symptom management, utilizing prescription drugs, physical therapy and/or other Medically Necessary services to address a Member's pain and other symptoms. The Member's plan of care shall include all services authorized for pain and symptom management.

7. Mental health and medical social services shall be available to the Member to assist in minimizing the stress and psychological problems that may arise from a serious illness, related conditions, and the dying process. Counseling facilitated by the Palliative Care team may include, but is not limited to:

   a. Psychotherapy;

   b. Bereavement counseling;

   c. Medical social services; and

   d. Discharge planning, as appropriate.

   e. Provision of medical social services shall not duplicate Specialty Mental Health Services provided by the Orange County Health Care Agency (HCA) and shall not change CalOptima's or a Health Network's responsibilities for referring to, and coordinating with the Orange County HCA.

H. CalOptima or a Health Network shall periodically assess for changes in the Member's condition or Palliative Care needs. CalOptima or a Health Network may discontinue Palliative Care that is no longer Medically Necessary or reasonable.

I. A Member may receive Palliative Care concurrently with Curative Care and may elect to transition to Hospice Care if the Member meets the hospice eligibility criteria. A Member may not receive Palliative Care and Hospice Care concurrently, except as described in Section II.J of this policy.

J. A Member under age of twenty-one (21) may be eligible for Palliative Care and Hospice Care services concurrently with Curative Care through other existing programs such as Home and Community Based Services (HCBS) waiver known as Pediatric Palliative Care Program (PPC) or concurrent care under Section 3202 of the Affordable Care Act (ACA).

K. CalOptima or a Health Network shall be responsible for providing Hospice Care services for Terminally Ill Members in accordance with CalOptima Policy GG.1503: CalOptima Hospice Coverage, Notification and Validation Requirements.

L. For Members enrolled in CalOptima Direct, CalOptima shall be responsible for design, planning and implementation of the Palliative Care program in accordance with this Policy and shall monitor, collect, and analyze referral, encounter and claims data to evaluate the effectiveness of Palliative Care services and to promote continuous quality improvement in accordance with Section III.B. of this Policy.

M. Health Networks shall be responsible for design, planning, referrals and implementation of Palliative Care services for their Members, at a minimum, in accordance with SB 1004 (2014) and DHCS APL 17-015: Palliative Care and Medi-Cal Managed Care. CalOptima shall ensure Health Networks comply with SB 1004 (2014) and DHCS APL 17-015: Palliative Care and Medi-Cal Managed Care and shall provide oversight of Health Network functions and responsibilities, processes, and performance in accordance with CalOptima Policy GG.1619: Delegation Oversight.

N. A Health Network shall collect and submit to CalOptima Palliative Care enrollment, provider, and utilization data in accordance with CalOptima Policies HH.2003: Health Network Reporting, EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory, and EE.1111: Health Network Encounter Reporting Requirements. CalOptima shall provide monitoring and oversight for Health Network enrollment and utilization of Palliative Care services as well as aggregation of data required for DHCS reporting in accordance with GG.1541: Utilization Management Delegation and GG.1532: Over and Under Utilization Monitoring.

III. PROCEDURE

A. CalOptima or a Health Network shall authorize Palliative Care services when a Member meets the minimum eligibility requirements in accordance with Sections II.C. and E. of this Policy without regard to the Member's age.

1. For a CalOptima Direct Member, a Provider shall submit a routine Prior Authorization Request (ARF) for Palliative Care based on Medical Necessity and eligibility criteria and in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals. For a Health Network Member, a Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

B. CalOptima shall identify potentially eligible Members for Palliative Care services through various sources, including, but not limited to:

1. Prior Authorization referrals;
2. Concurrent review referrals;
3. Case management referrals;
4. Disease management referrals;
5. Provider referrals; and
6. Claims and encounter data.

C. Provider Training and Education

1. CalOptima shall ensure Provider education and training on Palliative Care services available, identification and referral of eligible Members, and how care will be coordinated between Providers in accordance with CalOptima Policy EE.1103: Provider Education and Training. Provider education shall be provided, at a minimum, as follows:

    a. Provider office education and training;

    b. Provider manual updates;

    c. Provider monthly newsletter; and/or

    d. Provider quarterly Lunch and Learn educational updates.

2. Provider education shall also focus on ensuring Members who are eligible for Palliative Care services are referred from both PCPs, as well as appropriate specialists including, but not limited to:

    a. Oncologists;

    b. Hematologists;

    c. Pulmonologists; and

    d. Cardiologists.

D. CalOptima shall ensure a Member receives Palliative Care services within timely access standards in accordance with CalOptima Policy GG.1600: Access and Availability.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies GG.1510: Appeals Process for Decisions Regarding Care and Services, HH.1102: CalOptima Member Complaint, and HH.1108: State Hearing Process and Procedures.

F. CalOptima shall report Palliative Care data to DHCS in a manner and format required by DHCS.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services
B. Department of Health Care Services (DHCS) All Plan Letter 17-015: Palliative Care and Medi-Cal Managed Care
C. Department of Health Care Services (DHCS) All Plan Letter 13-014: Hospice Services and Medi-Cal Managed Care
D. Department of Health Care Services (DHCS) Policy Letter 11-004: The Implementation of Section 2302 of the Affordable Care Act, Entitled “Concurrent Care For Children”

E. CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory
F. CalOptima Policy EE.1103: Provider Education and Training
G. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
H. CalOptima Policy GG.1503: CalOptima Hospice Coverage, Notification and Validation Requirements
I. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
J. CalOptima Policy GG.1532: Over and Under Utilization Monitoring
K. CalOptima Policy GG.1541: Utilization Management Delegation and
L. CalOptima Policy GG.1600: Access and Availability
M. CalOptima Policy GG.1619: Delegation Oversight
N. CalOptima Policy HH.1102: CalOptima Member Complaint
O. CalOptima Policy HH.1108: State Hearing Process and Procedures
P. CalOptima Policy HH.2003: Health Network Reporting
Q. Affordable Care Act, §2302
R. Welfare and Institutions Code §14132.75

VI. REGULATORY AGENCY APPROVALS

A. 11/15/17: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2018	GG.1550	Palliative Care Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Advance Care Planning	Documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker.
Advance Directive	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a Member is incapacitated.
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of the Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access by Member's Authorized Representative.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Curative Care	Health care practices that treat patients with the intent of curing them, not just reducing their pain or stress
Health Network	A Physician Hospital Consortium (PHC), physician medical group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.

Term	Definition
Hospice Care	The provision of palliative and supportive items and services to a Terminally Ill Member as defined in Title 22 CCR section 51180.2, who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider or by others under arrangements made by a hospice provider, including: 1. Nursing services; 2. Physical or occupational therapy, or speech-language pathology; 3. Medical social services under the direction of a physician; 4. Home health aide and homemaker services; 5. Medical supplies and appliances; 6. Drugs and biologicals; 7. Physician Services; 8. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility; 9. Counseling, including bereavement, dietary and spiritual counseling; 10. Continuous nursing services provided on a twenty-four (24)-hour basis only during periods of Crisis and only as necessary to maintain the Terminally Ill Member at home; 11. Inpatient Respite Care provided on an intermittent, non-routine and occasional basis for up to five (5) consecutive days at a time in a hospital, skilled nursing or hospice facility; and 12. Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Palliative Care	Patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.
Primary Care Provider	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

Term	Definition
Specialty Mental Health Services	Rehabilitation services, which include mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and *psychiatric* health facility services. Specialty Mental Health Services may also include: 1. Psychiatric Inpatient Hospital Services; 2. Targeted Case Management; 3. Psychiatrist services; 4. Psychologist services; 5. Early Periodic Screening, Detection, and Treatment (EPSDT) supplemental Specialty Mental Health Services; and/or 6. Psychiatric nursing facility services.

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Board of Directors Meeting
December 7, 2017

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
Member Advisory Committee Update

October 26, 2017 OneCare Connect Member Advisory Committee Meeting
The OneCare Connect Member Advisory Committee (OCC MAC) voted on items at the October 26, 2017 meeting, including considering three new OCC MAC members and amending the FY 2017-18 meeting schedule. OCC MAC recommends that the Board of Directors approve non-voting agency representatives Jyothi Atluri from the Social Services Agency (SSA) and Amber Nowak from the In-Home Supportive Services Public Authority (IHSS PA), as well as member/family member voting representative Kristin Trom. In addition, OCC MAC voted to amend its FY 2017-18 meeting schedule to bimonthly beginning in January 2018.

OCC MAC received the following informational updates. Dr. Nguyen, Palliative Program Director, Hoag Hospital, presented the challenges and best practices of Physician Orders for Life-Sustaining Treatment (POLST) in Orange County. Dr. Calvet, Orange County Deputy Health Officer, Health Care Agency, presented on Orange County's efforts to improve older adult health. Carlos Soto, Manager, Cultural & Linguistic (C&L) Services, explained that C&L provides communication services to members in their language through several defined goals and objectives.

OCC MAC received executive staff updates on items that impact CalOptima, such as: the transition to integrate the administration of Medi-Cal covered behavioral health benefits into CalOptima internal operations, effective January 1, 2018 and CalOptima's request for Letters of Interest (LOIs) from organizations to fund Community Grant Initiatives (Intergovernmental Transfers 6 and 7).

November 16, 2017 OCC MAC Meeting
At the November 16, 2017 meeting, OCC MAC welcomed new OCC MAC Members Jyothi Atluri, SSA, Amber Nowak, IHSS PA, and Kristin Trom, OCC member/family member.

OCC MAC received the following informational updates. Melissa Tober, Health Care Agency, and Roseann Peters, Lestonnac Free Clinic, presented an update on Whole Person Care and the Community Referral Network, which is an on-line referral system designed to facilitate referrals to community clinics, hospitals, and social service agencies to provide holistic care for their clients. Member Sara Lee, Legal Aid Society of Orange County, provided a quarterly update on the Ombudsman Service Program, which continues to assist members with OCC enrollment issues and potential OCC disenrollment due to Medi-Cal eligibility issues.

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OCC MAC received executive staff updates on the following: CalOptima's efforts to expand the Program of All-Inclusive Care for the Elderly (PACE) in Orange County; the transition of Medi-Cal behavioral health services to CalOptima, effective 1/1/18; and the passage by the House to reauthorize funding for the Children's Health Insurance Program (CHIP) for five years. CalOptima asked for OCC MAC's assistance in reaching out to California's senators to support its passage.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

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Board of Directors Meeting
December 7, 2017

Member Advisory Committee Update

At the November 9, 2017 Member Advisory Committee (MAC) meeting, MAC received the following informational updates. Melissa Tober, Health Care Agency, and Roseann Peters, Lestonnac Free Clinic, presented an update on Whole Person Care and the Community Referral Network, which is an on-line referral system designed to facilitate referrals to community clinics, hospitals, and social service agencies to provide holistic care for their clients. Dr. Sharps, Medical Director, Behavioral Health, discussed CalOptima's efforts to enhance Applied Behavioral Analysis (ABA) provider accessibility and availability upon the transition of behavioral health services to CalOptima, effective 1/1/18. Carlos Soto, Manager, Cultural & Linguistic (C&L) Services, explained that C&L provides communication services to members in their language through several defined goals and objectives. Kelly Rex-Kimmet, Director, Quality Analytics, presented the Medi-Cal Healthcare Effectiveness Data and Information Set (HEDIS) results for 2016 data and the baseline results for OneCare Connect. In addition, Ms. Rex-Kimmet provided the member experience findings from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Tracy Hitzeman, Executive Director, Clinical Operations, discussed CalOptima's requirement to establish standards and provide technical assistance to ensure delivery of palliative care services for Medi-Cal members no later than 1/1/18.

Chair Sally Molnar asked if MAC members were interested in convening another joint advisory committee meeting with the Provider Advisory Committee (PAC). Upon MAC members agreement, Chair Molnar asked for volunteers to serve on an ad hoc subcommittee with PAC representatives to develop an agenda. Chair Molnar and Members Patty Mouton and Christine Tolbert volunteered for the ad hoc. In addition, Chair Molnar reviewed MAC's progress towards meeting its FY 2017-18 Goals and Objectives, reporting that MAC has completed most of its targets.

MAC received the following executive staff updates, including the Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Executive Director of Network Operations and the Executive Director of Government Affairs. These updates included items that impact CalOptima, such as: the transition toward CalOptima administering the ABA benefit and coordinating and managing the care for less than severe and persistent mental illness, effective 1/1/18; CalOptima's progress to expand the Program of All-Inclusive Care for the Elderly (PACE) in Orange County; and the passage of H.R. 3922 by the House to reauthorize funding for the Children's Health Insurance Program (CHIP) for five years. CalOptima asked for MAC's support to reach out to California's senators to ensure Senate passage.

The MAC appreciates the opportunity to provide the CalOptima Board with input and updates on the MAC's activities.

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Board of Directors Meeting
December 7, 2017

Provider Advisory Committee (PAC) Update

November 9, 2017 PAC Meeting

Thirteen (13) PAC members were in attendance at the November PAC meeting.

PAC approved the recommendation of the Orange County Health Care Agency (OCHCA) to appoint Mary R. Hale, Director, Behavioral Health to fill the OCHCA standing seat on the PAC. Alan Edwards, M.D., notified the PAC of his pending retirement and resigned from his seat on the PAC.

Michael Schrader, Chief Executive Officer, updated the PAC on the top three PACE initiatives and noted that there were currently 235 members utilizing the PACE services. PACE is now running a morning session as well as an afternoon session for the current membership which seems to be working out well for the members.

Richard Bock, M.D., Deputy Chief Medical Officer, announced that DHCS had awarded CalOptima the highest quality award in California. Dr. Bock noted that October was National Pharmacy Month and he thanked Member Pham for inviting him to the Orange County's Pharmacy Association event and acknowledged the excellent work being done in county by pharmacists, especially with all the challenges being faced due to the high cost of medications. Dr. Bock also discussed the Pay for Value program (P4V) and noted that the first P4V checks would be issued soon. Dr. Bock touched upon the opioid epidemic and the PAC asked him to return to the December meeting with in depth presentation of the opioid epidemic.

PAC also received an update on CalOptima's financial performance through the month of September 2017 from Greg Hamlin, Chief Financial Officer.

Michelle Laughlin, Executive Director Network Operations, provided the PAC with an update on the Magellan transition. Ms. Laughlin noted that as of November 8, 2017, 85% of mental health providers had been contracted and 80% of the ABA providers had returned signed contracts. CalOptima will offer Continuity of Care for a year to members whose provider is not contracted with CalOptima.

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, provided the PAC with an update on the Children's Health Insurance Program (CHIP) in Orange County and noted that a reauthorization that was signed in to law in 2015, which funded CHIP through September 30, 2017 and had expired, had been reinstated by Congress for an additional five (5) years and approved $3 billion for this program. The current funding is split between the Federal and State at 88%/12%. The reinstatement keeps the current Federal and State split the same for two (2) years and the final three (3) years reverts back to the original split of 65%/35%.

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Other updates included presentations on the Community Referral Network by Melissa Tober, Manager of Strategic Projects at the OCHCA and Roseann Peters, Program Manager at Lestonnac Free Clinic. Tracy Hitzeman, Executive Director, Clinical Operations provided an update on Palliative Care and Pamela Pimentel, Chief Executive Officer, MOMS of Orange County presented on Maternal Mood and Anxiety Disorders.

PAC members reviewed the first quarter progress of their Goals and Objectives for 2017-18. PAC will have open dialogue at their next meeting on the difficulty of members accessing providers.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.

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Financial Summary

October 2017

Board of Directors Meeting

December 7, 2017

Greg Hamblin

Chief Financial Officer

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FY 2017-18: Consolidated Enrollment

- October 2017 MTD:
  - ➢ Overall enrollment was 780,645 member months
    - Actual lower than budget by 22,057 or 2.7%
      - Medi-Cal: unfavorable variance of 21,818 members
        - ➢ TANF unfavorable variance of 13,566 members
        - ➢ SPD unfavorable variance of 4,286 members
        - ➢ Medi-Cal Expansion (MCE) unfavorable variance of 3,965 members which includes a retro adjustment of 7,458 members
      - OneCare Connect: unfavorable variance of 297 members
    - 15,536 or 2.0% decrease from prior month
      - Medi-Cal: decrease of 15,506 from September
      - OneCare Connect: decrease of 31 from September
      - OneCare: increase of 2 from September
      - PACE: decrease of 1 from September

FY 2017-18: Consolidated Enrollment

- October 2017 YTD:
  - Overall enrollment was 3,162,503 member months
    - Actual lower than budget by 46,334 or 1.4%
      - Medi-Cal: unfavorable variance of 45,631 members or 1.5%
        - TANF unfavorable variance of 44,336 members
        - SPD unfavorable variance of 11,001 members
        - MCE favorable variance of 9,127 members
        - LTC favorable variance of 579 members
      - OneCare Connect: unfavorable variance of 945 members or 1.5%
      - OneCare: favorable variance of 245 members or 4.6%
      - PACE: unfavorable variance of 3 member or 0.3%

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FY 2017-18: Consolidated Revenues

- October 2017 MTD:
  - Actual higher than budget by $4.3 million or 1.5%
    - Medi-Cal: favorable to budget by $3.6 million or 1.4%
      - Unfavorable volume variance of $6.8 million due mainly to retro enrollment adjustment offset by $6.2 million release of prior year contingency reserve
      - Favorable price variance of $4.2 million due to:
        - $2.5 million of fiscal year 2018 Coordinated Care Initiative (CCI) including In-Home Supportive Services revenue (IHSS)
        - $1.9 million of fiscal year 2018 Behavioral Health Treatment (BHT) Revenue

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FY 2017-18: Consolidated Revenues (cont.)

- October 2017 MTD:
  - OneCare Connect: favorable to budget by $0.3 million or 1.0%
    - Unfavorable volume variance of $0.5 million due to lower enrollment
    - Favorable price variance of $0.8 million due to higher than anticipated RAF score
  - OneCare: favorable to budget by $0.5 million or 33.5%
    - Favorable volume variance of $0.1 million
    - Favorable price variance of $0.4 million due to higher than anticipated RAF score and prior year adjustments
  - PACE: unfavorable to budget by $46.8 thousand or 3.1%
    - Unfavorable volume variance of $26.4 thousand
    - Unfavorable price variance of $20.4 thousand

FY 2017-18: Consolidated Revenues (cont.)

- October 2017 YTD:
  - Actual higher than budget by $38.1 million or 3.5%
    - Medi-Cal: favorable to budget by $33.5 million or 3.4%
      - Unfavorable volume variance of $14.2 million offset by $6.2 million release of prior year contingency reserve
      - Favorable price variance of $41.5 million due to:
        - $17.8 million for combined CCI including IHSS revenue
        - $5.7 million for Behavioral Health Treatment (BHT) Revenue
        - $15.9 million for prior year revenue
    - OneCare Connect: favorable to budget by $5.9 million or 5.4%
      - Unfavorable volume variance of $1.7 million
      - Favorable price variance of $7.6 million due to higher than anticipated RAF score and prior year revenue

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FY 2017-18: Consolidated Revenues (cont.)

- October 2017 YTD:
  - OneCare: Unfavorable to budget by $1.8 million or 32.8%
    - Favorable volume variance of $0.3 million
    - Unfavorable price variance of $2.0 million
      - $2.8 million due to CMS recoupment for prior years
  - PACE: favorable to budget by $0.5 million or 7.8%
    - Favorable price variance of $0.5 million due to prior year revenue

FY 2017-18: Consolidated Medical Expenses

- October 2017 MTD:
  - ➢ Actual higher than budget by $6.1 million or 2.3%
    - ▪ Medi-Cal: unfavorable variance of $5.4 million
      - Facilities expenses favorable variance of $3.7 million
      - Provider Capitation unfavorable variance of $3.6 million
      - MLTSS unfavorable variance of $3.2 million
        - ➢ IHSS unfavorable variance of $4.0 million
      - Professional Claims unfavorable variance of $1.0 million
      - Prescription Drugs unfavorable variance of $1.1 million

    - OneCare Connect: unfavorable variance of $0.8 million
      - Favorable volume variance of $0.5 million
      - Unfavorable price variance of $1.3 million

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FY 2017-18: Consolidated Medical Expenses (cont.)

- October 2017 YTD:
  - Actual higher than budget by $49.5 million or 4.7%
    - Medi-Cal: unfavorable variance of $49.3 million
      - Favorable volume variance of $13.6 million
      - Unfavorable price variance of $62.9 million
        - MLTSS expense $29.2 million higher than budget
        - Provider Capitation $14.6 million higher than budget
        - Professional Claims $8.4 million higher than budget
        - Facilities $5.1 million higher than budget
    - OneCare Connect: unfavorable variance of $3.7 million
      - Favorable volume variance of $1.6 million
      - Unfavorable price variance of $5.2 million
- Medical Loss Ratio (MLR):
  - October 2017 MTD: Actual: 96.5% Budget: 95.7%
  - October 2017 YTD: Actual: 96.2% Budget: 95.1%

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FY 2017-18: Consolidated Administrative Expenses

- October 2017 MTD:
  - Actual lower than budget by $2.8 million or 23.4%
    - Salaries and Benefits: favorable variance of $0.8 million
    - Other categories: favorable variance of $2.1 million

- October 2017 YTD:
  - Actual lower than budget by $10.8 million or 22.4%
    - Salaries and Benefits: favorable variance of $3.5 million driven by lower than budgeted FTE
    - Other categories: favorable variance of $7.3 million

- Administrative Loss Ratio (ALR):
  - October 2017 MTD: Actual: 3.3% Budget: 4.4%
  - October 2017 YTD: Actual: 3.3% Budget: 4.4%

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FY 2017-18: Change in Net Assets

- October 2017 MTD:
  - $2.5 million surplus
  - $2.6 million favorable to budget
    - Higher than budgeted revenue of $4.3 million
    - Higher than budgeted medical expenses of $6.1 million
    - Lower than budgeted administrative expenses of $2.8 million
    - Higher than budgeted investment and other income of $1.6 million

- October 2017 YTD:
  - $13.8 million surplus
  - $6.7 million favorable to budget
    - Higher than budgeted revenue of $38.1 million
    - Higher than budgeted medical expenses of $49.5 million
    - Lower than budgeted administrative expenses of $10.8 million
    - Higher than budgeted investment and other income of $7.3 million

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Enrollment Summary: October 2017

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
60,871	63,017	(2,146)	(3.4%)	Aged	245,871	249,741	(3,870)	(1.5%)
552	618	(66)	(10.7%)	BCCTP	2,429	2,472	(43)	(1.7%)
46,702	48,776	(2,074)	(4.3%)	Disabled	187,951	195,039	(7,088)	(3.6%)
325,320	329,642	(4,322)	(1.3%)	TANF Child	1,307,625	1,319,429	(11,804)	(0.9%)
94,597	103,841	(9,244)	(8.9%)	TANF Adult	383,371	415,903	(32,532)	(7.8%)
3,267	3,268	(1)	(0.0%)	LTC	13,651	13,072	579	4.4%
232,469	236,434	(3,965)	(1.7%)	MCE	954,058	944,931	9,127	1.0%
763,778	**785,596**	**(21,818)**	**(2.8%)**	**Medi-Cal**	**3,094,956**	**3,140,587**	**(45,631)**	**(1.5%)**
15,234	**15,531**	**(297)**	**(1.9%)**	**OneCare Connect**	**61,093**	**62,038**	**(945)**	**(1.5%)**
227	**231**	**(4)**	**(1.7%)**	**PACE**	**891**	**894**	**(3)**	**(0.3%)**
1,406	**1,344**	**62**	**4.6%**	**OneCare**	**5,563**	**5,318**	**245**	**4.6%**
780,645	**802,702**	**(22,057)**	**(2.7%)**	**CalOptima Total**	**3,162,503**	**3,208,837**	**(46,334)**	**(1.4%)**

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Financial Highlights: October 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
780,645	802,702	(22,057)	(2.7%)	Member Months	3,162,503	3,208,837	(46,334)	(1.4%)
279,997,967	275,747,826	4,250,141	1.5%	Revenues	1,139,081,219	1,101,007,792	38,073,427	3.5%
270,075,616	263,996,393	(6,079,223)	(2.3%)	Medical Expenses	1,096,159,288	1,046,659,224	(49,500,064)	(4.7%)
9,257,028	12,089,098	2,832,070	23.4%	Administrative Expenses	37,389,862	48,183,422	10,793,560	22.4%
665,322	**(337,665)**	**1,002,987**	**297.0%**	**Operating Margin**	**5,532,069**	**6,165,146**	**(633,076)**	**(10.3%)**
1,844,895	231,157	1,613,738	698.1%	Non Operating Income (Loss)	8,286,896	967,402	7,319,494	756.6%
2,510,218	**(106,508)**	**2,616,725**	**2456.8%**	**Change in Net Assets**	**13,818,965**	**7,132,548**	**6,686,417**	**93.7%**
96.5%	95.7%	(0.7%)		Medical Loss Ratio	96.2%	95.1%	(1.2%)	
3.3%	4.4%	1.1%		Administrative Loss Ratio	3.3%	4.4%	1.1%	
0.2%	(0.1%)	0.4%		Operating Margin Ratio	0.5%	0.6%	(0.1%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: October (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
0.3	(0.3)	0.6	Medi-Cal	0.0	6.7	(6.7)
(0.1)	0.2	(0.3)	OCC	3.8	0.3	3.5
0.3	(0.1)	0.5	OneCare	0.9	(0.6)	1.5
0.2	(0.1)	0.2	PACE	0.7	(0.2)	1.0
0.6	**(0.3)**	**1.0**	**Operating**	**5.5**	**6.2**	**(0.7)**
1.9	0.2	1.6	Inv./Rental Inc, MCO tax	8.3	1.0	7.3
1.9	**0.2**	**1.6**	**Non-Operating**	**8.3**	**1.0**	**7.3**
2.5	**(0.1)**	**2.6**	**TOTAL**	**13.8**	**7.1**	**6.7**

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Consolidated Revenue & Expense: October 2017 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	531,309	232,469	763,778	15,234	1,406	227	780,645
REVENUES							
Capitation Revenue	$ 147,638,268	$ 101,072,503	$ 248,710,771	$ 27,928,548	$ 1,883,126	$ 1,475,522	$ 279,997,967
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	147,638,268	101,072,503	248,710,771	27,928,548	1,883,126	1,475,522	279,997,967
MEDICAL EXPENSES							
Provider Capitation	39,952,086	50,674,304	90,626,391	11,469,777	548,437	-	102,644,605
Facilities	22,594,319	17,890,547	40,484,866	2,174,336	322,811	118,668	43,100,680
Ancillary	-	-	-	505,167	67,238	-	572,406
Skilled Nursing	-	-	-	-	42,128	-	42,128
Professional Claims	7,211,212	7,949,507	15,160,719	-	-	366,989	15,527,708
Prescription Drugs	18,494,877	19,132,547	37,627,424	5,550,474	489,156	113,843	43,780,897
Quality Incentives	-	-	-	-	-	-	-
MLTSS Facility Payments	51,042,319	2,424,946	53,467,265	5,508,982	-	(88)	58,976,158
Medical Management	1,860,670	885,096	2,745,765	1,061,406	17,894	525,384	4,350,449
Reinsurance & Other	481,335	337,227	818,562	156,378	9,686	95,959	1,080,585
Total Medical Expenses	141,636,818	99,294,174	240,930,992	26,426,520	1,497,350	1,220,755	270,075,616
Medical Loss Ratio	**95.9%**	**98.2%**	**96.9%**	**94.6%**	**79.5%**	**82.7%**	**96.5%**
GROSS MARGIN	**6,001,450**	**1,778,329**	**7,779,779**	**1,502,028**	**385,777**	**254,767**	**9,922,351**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,290,246	770,831	20,264	69,869	6,151,210
Professional fees			126,275	16,238	0	2,213	144,725
Purchased services			499,034	(6,492)	10,988	3,990	507,520
Printing and Postage			267,372	108,504	11,914	183	387,972
Depreciation and Amortization			370,983	-	-	2,168	373,151
Other expenses			1,246,695	44,651	(32)	17,417	1,308,732
Indirect cost allocation, Occupancy expense			(297,686)	664,798	13,553	3,052	383,717
Total Administrative Expenses			7,502,918	1,598,529	56,688	98,893	9,257,028
Admin Loss Ratio			**3.0%**	**5.7%**	**3.0%**	**6.7%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			276,861	(96,501)	329,089	155,874	665,322
INVESTMENT INCOME			-	-	-	-	1,863,285
NET RENTAL INCOME			-	-	-	-	5,137
NET GRANT INCOME			(23,527)	-	-	-	(23,527)
OTHER INCOME			-	-	-	-	0
CHANGE IN NET ASSETS			**$ 253,334**	**$ (96,501)**	**$ 329,089**	**$ 155,874**	**$ 2,510,218**
BUDGETED CHANGE IN ASSETS			(318,318)	164,143	(130,545)	(52,945)	(106,508)
VARIANCE TO BUDGET - FAV (UNFAV)			571,651	(260,644)	459,634	208,819	2,616,725

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CalOptima A Public Agency Better. Together.

Consolidated Revenue & Expense: October 2017 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	2,140,898	954,058	3,094,956	61,093	5,563	891	3,162,503
REVENUES							
Capitation Revenue	$ 595,266,918	$ 418,102,867	$ 1,013,369,785	$ 115,700,324	3,672,507	$ 6,338,603	$ 1,139,081,219
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	595,266,918	418,102,867	1,013,369,785	115,700,324	3,672,507	6,338,603	1,139,081,219
MEDICAL EXPENSES							
Provider Capitation	156,612,904	201,185,982	357,798,886	45,359,817	(908,166)	-	402,250,536
Facilities	99,080,855	78,627,156	177,708,010	11,287,866	1,159,321	937,182	191,092,379
Ancillary	-	-	-	2,396,687	152,699	-	2,549,386
Skilled Nursing	-	-	-	-	94,683	-	94,683
Professional Claims	30,241,906	33,077,742	63,319,648	-	-	1,341,227	64,660,875
Prescription Drugs	71,532,910	74,316,720	145,849,630	20,652,922	1,910,085	442,777	168,855,413
MLTSS Facility Payments	213,748,466	9,914,645	223,663,111	20,884,462	-	16,302	244,563,875
Medical Management	8,283,634	2,818,991	11,102,625	4,201,374	69,195	2,054,716	17,427,910
Reinsurance & Other	2,207,986	1,309,215	3,517,201	726,405	31,035	389,589	4,664,231
Total Medical Expenses	581,708,660	401,250,450	982,959,110	105,509,534	2,508,852	5,181,792	1,096,159,288
Medical Loss Ratio	**97.7%**	**96.0%**	**97.0%**	**91.2%**	**68.3%**	**81.7%**	**96.2%**
GROSS MARGIN	**13,558,259**	**16,852,416**	**30,410,675**	**10,190,790**	**1,163,655**	**1,156,810**	**42,921,931**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			20,758,812	3,007,829	95,856	277,829	24,140,326
Professional fees			687,343	34,613	0	11,253	733,209
Purchased services			2,870,574	253,272	49,562	16,414	3,189,823
Printing and Postage			1,089,378	257,222	20,486	5,178	1,372,264
Depreciation and Amortization			1,743,583	-	-	8,600	1,752,183
Other expenses			4,514,938	192,533	(32)	71,303	4,778,742
Indirect cost allocation, Occupancy expense			(1,324,486)	2,659,193	54,212	34,396	1,423,316
Total Administrative Expenses			30,340,142	6,404,662	220,084	424,974	37,389,862
Admin Loss Ratio			**3.0%**	**5.5%**	**6.0%**	**6.7%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			70,533	3,786,128	943,571	731,837	5,532,069
INVESTMENT INCOME			-	-	-	-	8,323,414
NET RENTAL INCOME			-	-	-	-	20,381
NET GRANT INCOME			(57,319)	-	-	-	(57,319)
OTHER INCOME			419	-	-	-	419
CHANGE IN NET ASSETS			**$ 13,634**	**$ 3,786,128**	**$ 943,571**	**$ 731,837**	**$ 13,818,965**
BUDGETED CHANGE IN ASSETS			6,715,026	266,153	(582,697)	(233,336)	7,132,548
VARIANCE TO BUDGET - FAV (UNFAV)			(6,701,392)	3,519,975	1,526,268	965,173	6,686,417

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CalOptima A Public Agency Better. Together.

Balance Sheet: As of October 2017

ASSETS			LIABILITIES & FUND BALANCES	
Current Assets			Current Liabilities	
	Operating Cash	$595,875,265	Accounts payable	$26,835,297
	Investments	893,957,195	Medical claims liability	1,052,927,427
	Capitation receivable	348,723,749	Accrued payroll liabilities	12,213,097
	Receivables - Other	24,107,561	Deferred revenue	156,624,497
	Prepaid Expenses	4,326,372	Deferred lease obligations	178,046
			Capitation and withholds	445,423,990
	Total Current Assets	**1,866,990,142**	**Total Current Liabilities**	**1,694,202,355**
Capital Assets	Furniture and equipment	34,039,048	Other employment benefits liability	29,281,263
	Building/Leasehold improvements	5,883,665		
	505 City Parkway West	49,433,337	Net Pension Liabilities	16,279,542
		89,356,051	Long Term Liabilities	100,000
	Less: accumulated depreciation	(37,039,357)		
	Capital assets, net	**52,316,694**	**TOTAL LIABILITIES**	**1,739,863,160**
Other Assets	Restricted deposit & Other	300,000	Deferred inflows of Resources - Excess Earnings	-
			Deferred inflows of Resources - Changes in Assumptions	1,340,010
	Board-designated assets			
	Cash and cash equivalents	23,993,088	Tangible net equity (TNE)	89,267,130
	Long term investments	513,303,463	Funds in excess of TNE	638,010,227
	Total Board-designated Assets	537,296,552		
	Total Other Assets	**537,596,552**	**Net Assets**	**727,277,357**
	Deferred outflows of Resources - Pension Contributions	5,234,198		
	Deferred outflows of Resources - Difference in Experience	1,072,771		
	Deferred outflows of Resources - Excess Earnings	5,270,171		
TOTAL ASSETS & OUTFLOWS		**2,468,480,527**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,468,480,527**

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CalOptima A Public Agency Better. Together.

Board Designated Reserve and TNE Analysis
As of October 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,818,562				
	Tier 1 - Logan Circle	146,605,875				
	Tier 1 - Wells Capital	146,501,667				
Board-designated Reserve		439,926,104	307,284,558	477,235,282	132,641,546	(37,309,178)
TNE Requirement	Tier 2 - Logan Circle	97,370,448	89,267,130	89,267,130	8,103,317	8,103,317
	Consolidated:	537,296,552	396,551,688	566,502,412	140,744,863	(29,205,861)
	Current reserve level	*1.90*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

October 2017

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CalOptima - Consolidated
Financial Highlights
For the Four Months Ended October 31, 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
780,645	802,702	(22,057)	(2.7%)	Member Months	3,162,503	3,208,837	(46,334)	(1.4%)
279,997,967	275,747,826	4,250,141	1.5%	Revenues	1,139,081,219	1,101,007,792	38,073,427	3.5%
270,075,616	263,996,393	(6,079,223)	(2.3%)	Medical Expenses	1,096,159,288	1,046,659,224	(49,500,064)	(4.7%)
9,257,028	12,089,098	2,832,070	23.4%	Administrative Expenses	37,389,862	48,183,422	10,793,560	22.4%
665,322	**(337,665)**	**1,002,987**	**297.0%**	**Operating Margin**	**5,532,069**	**6,165,146**	**(633,076)**	**(10.3%)**
1,844,895	231,157	1,613,738	698.1%	Non Operating Income (Loss)	8,286,896	967,402	7,319,494	756.6%
2,510,218	**(106,508)**	**2,616,725**	**2456.8%**	**Change in Net Assets**	**13,818,965**	**7,132,548**	**6,686,417**	**93.7%**
96.5%	95.7%	(0.7%)		Medical Loss Ratio	96.2%	95.1%	(1.2%)	
3.3%	4.4%	1.1%		Administrative Loss Ratio	3.3%	4.4%	1.1%	
0.2%	(0.1%)	0.4%		Operating Margin Ratio	0.5%	0.6%	(0.1%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima
Financial Dashboard
For the Four Months Ended October 31, 2017

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	763,778	785,596	(21,818)	(2.8%)
OneCare Connect	15,234	15,531	(297)	(1.9%)
OneCare	1,406	1,344	62	4.6%
PACE	227	231	(4)	(1.7%)
Total	780,645	802,702	(22,057)	(2.7%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 253	$ (318)	$ 572	179.6%
OneCare Connect	(97)	164	(261)	(158.8%)
OneCare	329	(131)	460	352.1%
PACE	156	(53)	209	394.4%
505 Bldg.	5	(19)	24	127.3%
Investment Income & Other	1,863	250	1,613	645.3%
Total	$ 2,510	$ (107)	$ 2,617	2456.8%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.9%	96.1%	(0.8)
OneCare Connect	94.6%	92.5%	(2.1)
OneCare	79.5%	102.4%	22.9

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 7,503	$ 9,927	$ 2,424	24.4%
OneCare Connect	1,599	1,913	314	16.4%
OneCare	57	97	40	41.7%
PACE	99	152	53	34.8%
Total	$ 9,257	$ 12,089	$ 2,832	23.4%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	872	900	29
OneCare Connect	220	237	17
OneCare	3	3	0
PACE	54	64	10
Total	1,149	1,205	56

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	876	872	4
OneCare Connect	69	66	4
OneCare	474	448	26
PACE	4	4	1
Total	1,423	1,390	34

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	3,094,956	3,140,587	(45,631)	(1.5%)
OneCare Connect	61,093	62,038	(945)	(1.5%)
OneCare	5,563	5,318	245	4.6%
PACE	891	894	(3)	(0.3%)
Total	3,162,503	3,208,837	(46,334)	(1.4%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 14	$ 6,715	$ (6,701)	(99.8%)
OneCare Connect	3,786	266	3,520	1322.5%
OneCare	944	(583)	1,526	261.9%
PACE	732	(233)	965	413.6%
505 Bldg.	20	(33)	53	162.5%
Investment Income & Other	8,323	1,000	7,323	732.3%
Total	$ 13,819	$ 7,133	$ 6,686	93.7%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.0%	95.3%	(1.7)
OneCare Connect	91.2%	92.8%	1.6
OneCare	68.3%	103.4%	35.1

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 30,340	$ 39,530	$ 9,189	23.2%
OneCare Connect	6,405	7,664	1,259	16.4%
OneCare	220	396	176	44.4%
PACE	425	594	169	28.5%
Total	$ 37,390	$ 48,183	$ 10,794	22.4%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	3,491	3,602	111
OneCare Connect	904	948	45
OneCare	12	12	(0)
PACE	209	251	42
Total	4,616	4,813	197

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	887	872	15
OneCare Connect	68	65	2
OneCare	447	443	3
PACE	4	4	1
Total	1,405	1,384	21

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CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended October 31, 2017

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	780,645		802,702		(22,057)	
Revenues						
Medi-Cal	$ 248,710,771	$ 325.63	$ 245,157,913	$ 312.07	$ 3,552,858	$ 13.57
OneCare Connect	27,928,548	1,833.30	27,657,508	1,780.79	271,040	52.51
OneCare	1,883,126	1,339.35	1,410,108	1,049.19	473,018	290.16
PACE	1,475,522	6,500.10	1,522,297	6,590.03	(46,775)	(89.93)
Total Operating Revenue	279,997,967	358.68	275,747,826	343.52	4,250,141	15.15
Medical Expenses						
Medi-Cal	240,930,992	315.45	235,548,817	299.83	(5,382,175)	(15.61)
OneCare Connect	26,426,520	1,734.71	25,580,455	1,647.06	(846,065)	(87.65)
OneCare	1,497,350	1,064.97	1,443,470	1,074.01	(53,880)	9.04
PACE	1,220,755	5,377.77	1,423,651	6,162.99	202,896	785.22
Total Medical Expenses	270,075,616	345.96	263,996,393	328.88	(6,079,223)	(17.08)
Gross Margin	9,922,351	12.71	11,751,433	14.64	(1,829,082)	(1.93)
Administrative Expenses						
Salaries and Benefits	6,151,210	7.88	6,915,975	8.62	764,765	0.74
Professional fees	144,725	0.19	385,941	0.48	241,216	0.30
Purchased services	507,520	0.65	1,957,446	2.44	1,449,926	1.79
Printing and Postage	387,972	0.50	527,374	0.66	139,402	0.16
Depreciation and Amortization	373,151	0.48	463,298	0.58	90,147	0.10
Other	1,308,732	1.68	1,498,647	1.87	189,915	0.19
Indirect cost allocation, Occupancy expense	383,717	0.49	340,417	0.42	(43,300)	(0.07)
Total Administrative Expenses	9,257,028	11.86	12,089,098	15.06	2,832,070	3.20
Income (Loss) From Operations	665,322	0.85	(337,665)	(0.42)	1,002,987	1.27
Investment income						
Interest income	2,397,844	3.07	250,000	0.31	2,147,844	2.76
Realized gain/(loss) on investments	(223,985)	(0.29)	-	-	(223,985)	(0.29)
Unrealized gain/(loss) on investments	(310,574)	(0.40)	-	-	(310,574)	(0.40)
Total Investment Income	1,863,285	2.39	250,000	0.31	1,613,285	2.08
Net Rental Income	5,137	0.01	(18,843)	(0.02)	23,980	0.03
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(23,527)	(0.03)	-	-	(23,527)	(0.03)
QAF/IGT	-	-	-	-	-	-
Other Income	-	-	-	-	-	-
Change In Net Assets	**2,510,218**	**3.22**	**(106,508)**	**(0.13)**	**2,616,725**	**3.35**
Medical Loss Ratio	**96.5%**		**95.7%**		**(0.7%)**	
Administrative Loss Ratio	**3.3%**		**4.4%**		**1.1%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

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CalOptima - Consolidated
Statement of Revenue and Expenses
For the Four Months Ended October 31, 2017

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	3,162,503		3,208,837		(46,334)	
Revenues						
Medi-Cal	$ 1,013,369,785	$ 327.43	$ 979,892,553	$ 312.01	$ 33,477,232	$ 15.42
OneCare Connect	115,700,324	1,893.84	109,766,950	1,769.35	5,933,374	124.49
OneCare	3,672,507	660.17	5,466,370	1,027.90	(1,793,863)	(367.73)
PACE	6,338,603	7,114.03	5,881,919	6,579.33	456,684	534.70
Total Operating Revenue	1,139,081,219	360.18	1,101,007,792	343.12	38,073,427	17.07
Medical Expenses						
Medi-Cal	982,959,110	317.60	933,647,986	297.28	(49,311,124)	(20.32)
OneCare Connect	105,509,534	1,727.03	101,836,761	1,641.52	(3,672,773)	(85.51)
OneCare	2,508,852	450.99	5,653,178	1,063.03	3,144,326	612.04
PACE	5,181,792	5,815.70	5,521,299	6,175.95	339,507	360.25
Total Medical Expenses	1,096,159,288	346.61	1,046,659,224	326.18	(49,500,064)	(20.43)
Gross Margin	42,921,931	13.57	54,348,568	16.94	(11,426,637)	(3.37)
Administrative Expenses						
Salaries and Benefits	24,140,326	7.63	27,614,716	8.61	3,474,390	0.97
Professional fees	733,209	0.23	1,561,255	0.49	828,046	0.25
Purchased services	3,189,823	1.01	7,620,668	2.37	4,430,845	1.37
Printing and Postage	1,372,264	0.43	2,116,990	0.66	744,726	0.23
Depreciation and Amortization	1,752,183	0.55	1,853,192	0.58	101,009	0.02
Other	4,778,742	1.51	6,054,934	1.89	1,276,192	0.38
Indirect cost allocation, Occupancy expense	1,423,316	0.45	1,361,668	0.42	(61,648)	(0.03)
Total Administrative Expenses	37,389,862	11.82	48,183,422	15.02	10,793,560	3.19
Income (Loss) From Operations	5,532,069	1.75	6,165,146	1.92	(633,076)	(0.17)
Investment income						
Interest income	8,701,898	2.75	1,000,000	0.31	7,701,898	2.44
Realized gain/(loss) on investments	(410,123)	(0.13)	-	-	(410,123)	(0.13)
Unrealized gain/(loss) on investments	31,640	0.01	-	-	31,640	0.01
Total Investment Income	8,323,414	2.63	1,000,000	0.31	7,323,414	2.32
Net Rental Income	20,381	0.01	(32,598)	(0.01)	52,979	0.02
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(57,319)	(0.02)	-	-	(57,319)	(0.02)
QAF/IGT	-	-	-	-	-	-
Other Income	419	0.00	-	-	419	0.00
Change In Net Assets	**13,818,965**	**4.37**	**7,132,548**	**2.22**	**6,686,417**	**2.15**
Medical Loss Ratio	**96.2%**		**95.1%**		**(1.2%)**	
Administrative Loss Ratio	**3.3%**		**4.4%**		**1.1%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended October 31, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	531,309	232,469	763,778	15,234	1,406	227	780,645
REVENUES							
Capitation Revenue	$ 147,638,268	$ 101,072,503	$ 248,710,771	$ 27,928,548	$ 1,883,126	$ 1,475,522	$ 279,997,967
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	147,638,268	101,072,503	248,710,771	27,928,548	1,883,126	1,475,522	279,997,967
MEDICAL EXPENSES							
Provider Capitation	39,952,086	50,674,304	90,626,391	11,469,777	548,437	-	102,644,605
Facilities	22,594,319	17,890,547	40,484,866	2,174,336	322,811	118,668	43,100,680
Ancillary	-	-	-	505,167	67,238	-	572,406
Skilled Nursing	-	-	-	-	42,128	-	42,128
Professional Claims	7,211,212	7,949,507	15,160,719	-	-	366,989	15,527,708
Prescription Drugs	18,494,877	19,132,547	37,627,424	5,550,474	489,156	113,843	43,780,897
Quality Incentives	-	-	-	-	-	-	-
MLTSS Facility Payments	51,042,319	2,424,946	53,467,265	5,508,982	-	(88)	58,976,158
Medical Management	1,860,670	885,096	2,745,765	1,061,406	17,894	525,384	4,350,449
Reinsurance & Other	481,335	337,227	818,562	156,378	9,686	95,959	1,080,585
Total Medical Expenses	141,636,818	99,294,174	240,930,992	26,426,520	1,497,350	1,220,755	270,075,616
Medical Loss Ratio	**95.9%**	**98.2%**	**96.9%**	**94.6%**	**79.5%**	**82.7%**	**96.5%**
GROSS MARGIN	**6,001,450**	**1,778,329**	**7,779,779**	**1,502,028**	**385,777**	**254,767**	**9,922,351**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,290,246	770,831	20,264	69,869	6,151,210
Professional fees			126,275	16,238	0	2,213	144,725
Purchased services			499,034	(6,492)	10,988	3,990	507,520
Printing and Postage			267,372	108,504	11,914	183	387,972
Depreciation and Amortization			370,983	-	-	2,168	373,151
Other expenses			1,246,695	44,651	(32)	17,417	1,308,732
Indirect cost allocation, Occupancy expense			(297,686)	664,798	13,553	3,052	383,717
Total Administrative Expenses			7,502,918	1,598,529	56,688	98,893	9,257,028
Admin Loss Ratio			**3.0%**	**5.7%**	**3.0%**	**6.7%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			276,861	(96,501)	329,089	155,874	665,322
INVESTMENT INCOME			-	-	-	-	1,863,285
NET RENTAL INCOME			-	-	-	-	5,137
NET GRANT INCOME			(23,527)	-	-	-	(23,527)
OTHER INCOME			-	-	-	-	0
CHANGE IN NET ASSETS			**$ 253,334**	**$ (96,501)**	**$ 329,089**	**$ 155,874**	**$ 2,510,218**
BUDGETED CHANGE IN ASSETS			(318,318)	164,143	(130,545)	(52,945)	(106,508)
VARIANCE TO BUDGET - FAV (UNFAV)			571,651	(260,644)	459,634	208,819	2,616,725

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Four Months Ended October 31, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	2,140,898	954,058	3,094,956	61,093	5,563	891	3,162,503
REVENUES							
Capitation Revenue	$ 595,266,918	$ 418,102,867	$ 1,013,369,785	$ 115,700,324	3,672,507	$ 6,338,603	$ 1,139,081,219
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	595,266,918	418,102,867	1,013,369,785	115,700,324	3,672,507	6,338,603	1,139,081,219
MEDICAL EXPENSES							
Provider Capitation	156,612,904	201,185,982	357,798,886	45,359,817	(908,166)	-	402,250,536
Facilities	99,080,855	78,627,156	177,708,010	11,287,866	1,159,321	937,182	191,092,379
Ancillary	-	-	-	2,396,687	152,699	-	2,549,386
Skilled Nursing	-	-	-	-	94,683	-	94,683
Professional Claims	30,241,906	33,077,742	63,319,648	-	-	1,341,227	64,660,875
Prescription Drugs	71,532,910	74,316,720	145,849,630	20,652,922	1,910,085	442,777	168,855,413
MLTSS Facility Payments	213,748,466	9,914,645	223,663,111	20,884,462	-	16,302	244,563,875
Medical Management	8,283,634	2,818,991	11,102,625	4,201,374	69,195	2,054,716	17,427,910
Reinsurance & Other	2,207,986	1,309,215	3,517,201	726,405	31,035	389,589	4,664,231
Total Medical Expenses	581,708,660	401,250,450	982,959,110	105,509,534	2,508,852	5,181,792	1,096,159,288
Medical Loss Ratio	**97.7%**	**96.0%**	**97.0%**	**91.2%**	**68.3%**	**81.7%**	**96.2%**
GROSS MARGIN	**13,558,259**	**16,852,416**	**30,410,675**	**10,190,790**	**1,163,655**	**1,156,810**	**42,921,931**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			20,758,812	3,007,829	95,856	277,829	24,140,326
Professional fees			687,343	34,613	0	11,253	733,209
Purchased services			2,870,574	253,272	49,562	16,414	3,189,823
Printing and Postage			1,089,378	257,222	20,486	5,178	1,372,264
Depreciation and Amortization			1,743,583	-	-	8,600	1,752,183
Other expenses			4,514,938	192,533	(32)	71,303	4,778,742
Indirect cost allocation, Occupancy expense			(1,324,486)	2,659,193	54,212	34,396	1,423,316
Total Administrative Expenses			30,340,142	6,404,662	220,084	424,974	37,389,862
Admin Loss Ratio			**3.0%**	**5.5%**	**6.0%**	**6.7%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			70,533	3,786,128	943,571	731,837	5,532,069
INVESTMENT INCOME			-	-	-	-	8,323,414
NET RENTAL INCOME			-	-	-	-	20,381
NET GRANT INCOME			(57,319)	-	-	-	(57,319)
OTHER INCOME			419	-	-	-	419
CHANGE IN NET ASSETS			**$ 13,634**	**$ 3,786,128**	**$ 943,571**	**$ 731,837**	**$ 13,818,965**
BUDGETED CHANGE IN ASSETS			6,715,026	266,153	(582,697)	(233,336)	7,132,548
VARIANCE TO BUDGET - FAV (UNFAV)			(6,701,392)	3,519,975	1,526,268	965,173	6,686,417

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SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $2.5 million, $2.6 million favorable to budget
- Operating surplus is $0.6 million with a surplus in non-operating of $1.9 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $13.8 million, $6.7 million favorable to budget
- Operating surplus is $5.5 million, $0.7 million unfavorable to budget

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
0.3	(0.3)	0.6	Medi-Cal	0.0	6.7	(6.7)
(0.1)	0.2	(0.3)	OCC	3.8	0.3	3.5
0.3	(0.1)	0.5	OneCare	0.9	(0.6)	1.5
0.2	(0.1)	0.2	PACE	0.7	(0.2)	1.0
0.6	**(0.3)**	**1.0**	**Operating**	**5.5**	**6.2**	**(0.7)**
1.9	0.2	1.6	Inv./Rental Inc, MCO tax	8.3	1.0	7.3
1.9	**0.2**	**1.6**	**Non-Operating**	**8.3**	**1.0**	**7.3**
2.5	**(0.1)**	**2.6**	**TOTAL**	**13.8**	**7.1**	**6.7**

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Enrollment Summary

For the Four Months Ended October 31, 2017

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
60,871	63,017	(2,146)	(3.4%)	Aged	245,871	249,741	(3,870)	(1.5%)
552	618	(66)	(10.7%)	BCCTP	2,429	2,472	(43)	(1.7%)
46,702	48,776	(2,074)	(4.3%)	Disabled	187,951	195,039	(7,088)	(3.6%)
325,320	329,642	(4,322)	(1.3%)	TANF Child	1,307,625	1,319,429	(11,804)	(0.9%)
94,597	103,841	(9,244)	(8.9%)	TANF Adult	383,371	415,903	(32,532)	(7.8%)
3,267	3,268	(1)	(0.0%)	LTC	13,651	13,072	579	4.4%
232,469	236,434	(3,965)	(1.7%)	MCE	954,058	944,931	9,127	1.0%
763,778	**785,596**	**(21,818)**	**(2.8%)**	**Medi-Cal**	**3,094,956**	**3,140,587**	**(45,631)**	**(1.5%)**
15,234	**15,531**	**(297)**	**(1.9%)**	**OneCare Connect**	**61,093**	**62,038**	**(945)**	**(1.5%)**
227	**231**	**(4)**	**(1.7%)**	**PACE**	**891**	**894**	**(3)**	**(0.3%)**
1,406	**1,344**	**62**	**4.6%**	**OneCare**	**5,563**	**5,318**	**245**	**4.6%**
780,645	**802,702**	**(22,057)**	**(2.7%)**	**CalOptima Total**	**3,162,503**	**3,208,837**	**(46,334)**	**(1.4%)**
				Enrollment (By Network)				
170,020	174,217	(4,197)	(2.4%)	HMO	684,137	696,367	(12,230)	(1.8%)
221,721	226,394	(4,673)	(2.1%)	PHC	891,936	907,264	(15,328)	(1.7%)
195,526	209,689	(14,163)	(6.8%)	Shared Risk Group	804,960	840,670	(35,710)	(4.2%)
176,511	175,296	1,215	0.7%	Fee for Service	713,923	696,286	17,637	2.5%
763,778	**785,596**	**(21,818)**	**(2.8%)**	**Medi-Cal**	**3,094,956**	**3,140,587**	**(45,631)**	**(1.5%)**
15,234	**15,531**	**(297)**	**(1.9%)**	**OneCare Connect**	**61,093**	**62,038**	**(945)**	**(1.5%)**
227	**231**	**(4)**	**(1.7%)**	**PACE**	**891**	**894**	**(3)**	**(0.3%)**
1,406	**1,344**	**62**	**4.6%**	**OneCare**	**5,563**	**5,318**	**245**	**4.6%**
780,645	**802,702**	**(22,057)**	**(2.7%)**	**CalOptima Total**	**3,162,503**	**3,208,837**	**(46,334)**	**(1.4%)**

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CalOptima
Enrollment Trend by Network Type
Fiscal Year 2018

Network Type	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	MMs
HMO													
Aged	4,058	4,045	4,051	3,864	-	-	-	-	-	-	-	-	16,018
BCCTP	1	1	1	5	-	-	-	-	-	-	-	-	8
Disabled	6,749	6,740	6,729	6,703	-	-	-	-	-	-	-	-	26,921
TANF Child	61,492	61,733	61,361	61,023	-	-	-	-	-	-	-	-	245,609
TANF Adult	30,429	30,420	30,313	30,127	-	-	-	-	-	-	-	-	121,289
LTC	3	4	6	4	-	-	-	-	-	-	-	-	17
MCE	68,020	68,792	69,169	68,294	-	-	-	-	-	-	-	-	274,275
	170,752	171,735	171,630	170,020	-	-	-	-	-	-	-	-	684,137
PHC													
Aged	1,480	1,493	1,530	1,401	-	-	-	-	-	-	-	-	5,904
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	7,318	7,264	7,258	7,236	-	-	-	-	-	-	-	-	29,076
TANF Child	162,801	163,976	163,202	162,046	-	-	-	-	-	-	-	-	652,025
TANF Adult	12,604	12,571	12,410	12,356	-	-	-	-	-	-	-	-	49,941
LTC	-	-	1	1	-	-	-	-	-	-	-	-	2
MCE	38,398	38,821	39,088	38,681	-	-	-	-	-	-	-	-	154,988
	222,601	224,125	223,489	221,721	-	-	-	-	-	-	-	-	891,936
Shared Risk Group													
Aged	3,809	3,756	3,831	3,029	-	-	-	-	-	-	-	-	14,425
BCCTP	-	-	-	1	-	-	-	-	-	-	-	-	1
Disabled	8,108	8,058	8,035	7,951	-	-	-	-	-	-	-	-	32,152
TANF Child	72,723	72,861	72,102	71,427	-	-	-	-	-	-	-	-	289,113
TANF Adult	32,775	32,737	32,316	31,441	-	-	-	-	-	-	-	-	129,269
LTC	-	1	2	-	-	-	-	-	-	-	-	-	3
MCE	85,799	86,330	86,191	81,677	-	-	-	-	-	-	-	-	339,997
	203,214	203,743	202,477	195,526	-	-	-	-	-	-	-	-	804,960
Fee for Service (Dual)													
Aged	48,036	48,599	48,846	48,863	-	-	-	-	-	-	-	-	194,344
BCCTP	25	22	25	23	-	-	-	-	-	-	-	-	95
Disabled	20,343	20,528	20,516	20,448	-	-	-	-	-	-	-	-	81,835
TANF Child	3	3	2	2	-	-	-	-	-	-	-	-	10
TANF Adult	1,205	1,226	1,184	1,156	-	-	-	-	-	-	-	-	4,771
LTC	3,002	3,124	3,126	3,068	-	-	-	-	-	-	-	-	12,320
MCE	2,816	2,848	2,758	2,831	-	-	-	-	-	-	-	-	11,253
	75,430	76,350	76,457	76,391	-	-	-	-	-	-	-	-	304,628
Fee for Service (Non-Dual)													
Aged	3,580	3,855	4,031	3,714	-	-	-	-	-	-	-	-	15,180
BCCTP	601	602	599	523	-	-	-	-	-	-	-	-	2,325
Disabled	4,466	4,559	4,578	4,364	-	-	-	-	-	-	-	-	17,967
TANF Child	27,513	31,414	31,119	30,822	-	-	-	-	-	-	-	-	120,868
TANF Adult	18,753	19,744	20,087	19,517	-	-	-	-	-	-	-	-	78,101
LTC	372	364	379	194	-	-	-	-	-	-	-	-	1,309
MCE	43,457	44,664	44,438	40,986	-	-	-	-	-	-	-	-	173,545
	98,742	105,202	105,231	100,120	-	-	-	-	-	-	-	-	409,295
MEDI-CAL TOTAL													
Aged	60,963	61,748	62,289	60,871	-	-	-	-	-	-	-	-	245,871
BCCTP	627	625	625	552	-	-	-	-	-	-	-	-	2,429
Disabled	46,984	47,149	47,116	46,702	-	-	-	-	-	-	-	-	187,951
TANF Child	324,532	329,987	327,786	325,320	-	-	-	-	-	-	-	-	1,307,625
TANF Adult	95,766	96,698	96,310	94,597	-	-	-	-	-	-	-	-	383,371
LTC	3,377	3,493	3,514	3,267	-	-	-	-	-	-	-	-	13,651
MCE	238,490	241,455	241,644	232,469	-	-	-	-	-	-	-	-	954,058
	770,739	781,155	779,284	763,778	-	-	-	-	-	-	-	-	3,094,956
PACE	215	221	228	227	-	-	-	-	-	-	-	-	891
OneCare	1,367	1,386	1,404	1,406	-	-	-	-	-	-	-	-	5,563
OneCare Connect	15,365	15,229	15,265	15,234	-	-	-	-	-	-	-	-	61,093
TOTAL	787,686	797,991	796,181	780,645	-	-	-	-	-	-	-	-	3,162,503

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ENROLLMENT:

Overall MTD enrollment was 780,645

- Unfavorable to budget by 22,057 or 2.7%
- Decreased 15,536 or 2.0% from prior month
- Decreased 17,640 from prior year (October 2016)

Medi-Cal enrollment was 763,778

- Unfavorable to budget by 21,818
    - TANF unfavorable by 13,566
    - SPD unfavorable by 4,286
    - Expansion unfavorable by 3,965
    - LTC unfavorable by 1
- Decreased 15,506 from prior month

OneCare Connect enrollment was 15,234

- Unfavorable to budget by 297
- Decreased 31 from prior month

OneCare enrollment was 1,406

- Favorable to budget by 62
- Increased 2 from prior month

PACE enrollment was 227

- Unfavorable to budget by 4
- Decreased 1 from prior month

CalOptima - Medi-Cal Total
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
763,778	785,596	(21,818)	(2.8%)	Member Months	3,094,956	3,140,587	(45,631)	(1.5%)
				Revenues				
248,710,771	245,157,913	3,552,858	1.4%	Capitation revenue	1,013,369,785	979,892,553	33,477,232	3.4%
248,710,771	245,157,913	3,552,858	1.4%	Total Operating Revenues	1,013,369,785	979,892,553	33,477,232	3.4%
				Medical Expenses				
90,626,391	87,007,525	(3,618,866)	(4.2%)	Provider capitation	357,798,886	348,255,291	(9,543,595)	(2.7%)
40,484,866	44,167,241	3,682,375	8.3%	Facilities	177,708,010	175,158,142	(2,549,868)	(1.5%)
15,160,719	14,119,679	(1,041,040)	(7.4%)	Professional Claims	63,319,648	55,700,856	(7,618,792)	(13.7%)
37,627,424	36,533,969	(1,093,455)	(3.0%)	Prescription drugs	145,849,630	143,312,318	(2,537,312)	(1.8%)
53,467,265	50,255,518	(3,211,747)	(6.4%)	MLTSS	223,663,111	197,379,938	(26,283,173)	(13.3%)
2,745,765	3,149,868	404,103	12.8%	Medical Management	11,102,625	12,581,373	1,478,748	11.8%
818,562	315,017	(503,545)	(159.8%)	Reinsurance & other	3,517,201	1,260,068	(2,257,133)	(179.1%)
240,930,992	235,548,817	(5,382,175)	(2.3%)	Total Medical Expenses	982,959,110	933,647,986	(49,311,124)	(5.3%)
7,779,779	9,609,096	(1,829,317)	(19.0%)	Gross Margin	30,410,675	46,244,567	(15,833,892)	(34.2%)
				Administrative Expenses				
5,290,246	5,902,819	612,573	10.4%	Salaries, wages & employee benefits	20,758,812	23,563,302	2,804,490	11.9%
126,275	329,274	203,000	61.7%	Professional fees	687,343	1,334,590	647,247	48.5%
499,034	1,684,302	1,185,268	70.4%	Purchased services	2,870,574	6,528,542	3,657,968	56.0%
267,372	398,738	131,366	32.9%	Printing and postage	1,089,378	1,594,946	505,568	31.7%
370,983	461,246	90,263	19.6%	Depreciation & amortization	1,743,583	1,844,984	101,401	5.5%
1,246,695	1,429,820	183,125	12.8%	Other operating expenses	4,514,938	5,778,317	1,263,379	21.9%
(297,686)	(278,785)	18,901	6.8%	Indirect cost allocation	(1,324,486)	(1,115,140)	209,346	18.8%
7,502,918	9,927,414	2,424,495	24.4%	Total Administrative Expenses	30,340,142	39,529,541	9,189,400	23.2%
				Operating Tax				
10,163,714	0	(10,163,714)	0.0%	Tax Revenue	54,397,685	0	(54,397,685)	0.0%
10,163,714	0	(10,163,714)	0.0%	Premium tax expense	41,020,583	0	(41,020,583)	0.0%
0	0	0	0.0%	Sales tax expense	13,377,102	0	(13,377,102)	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
(181,847)	291,249	(473,096)	(162.4%)	Grant Revenue	(107,668)	1,164,996	(1,272,664)	(109.2%)
(173,598)	258,276	431,874	167.2%	Grant expense - Service Partner	(109,807)	1,033,104	1,142,911	110.6%
15,278	32,973	17,695	53.7%	Grant expense - Administrative	59,457	131,892	72,435	54.9%
(23,527)	0	(23,527)	0.0%	Total Net Grant Income	(57,319)	0	(57,319)	0.0%
0	0	0	0.0%	Other income	419	0	419	0.0%
253,334	(318,318)	571,651	179.6%	Change in Net Assets	13,634	6,715,026	(6,701,392)	(99.8%)
96.9%	96.1%	(0 8%)	(0.8%)	Medical Loss Ratio	97.0%	95.3%	(1.7%)	(1.8%)
3.0%	4.0%	1 0%	25.5%	Admin Loss Ratio	3.0%	4.0%	1 0%	25.8%

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MEDI-CAL INCOME STATEMENT – OCTOBER MONTH:

REVENUES of $248.7 million are favorable to budget by $3.6 million, driven by:

- Unfavorable volume related variance of $6.8 million due to retro enrollment adjustment offset by $6.2 million release of prior year contingency reserve.

- Favorable price related variance of $4.2 million due to:
  - $2.5 million of fiscal year 2018 Coordinated Care Initiative (CCI) including In-Home Supportive Services revenue (IHSS)
  - $1.9 million of fiscal year 2018 Behavioral Health Treatment (BHT) Revenue

MEDICAL EXPENSES: Overall $241.0 million, unfavorable to budget by $5.4 million due to:

- **Facility** expense is favorable $3.7 million due to budgeting of Prospect capitation and Xover

- **Provider Capitation** is unfavorable $3.6 million due to BHT and Prospect capitation

- **Managed Long Term Services and Support (MLTSS)** is unfavorable to budget $3.2 million due to:

  - LTC unfavorable variance of $4.0 million adjustment of IHSS expense corresponding with the favorable CCI revenue variance above

- **Prescription Drug** expense is unfavorable $1.1 million

- **Professional Claim** expense is unfavorable to budget $1.0 million due to Xover

ADMINISTRATIVE EXPENSES are $7.5 million, favorable to budget $2.4 million, driven by:

- Purchased Services: $1.2 million favorable to budget

- Salary & Benefits: $0.6 million favorable to budget due to open positions

- Other Non-Salary: $0.6 million favorable to budget

CHANGE IN NET ASSETS is $0.3 million for the month, favorable to budget by $.0.6 million

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
15,234	15,531	(297)	(1.9%)	Member Months	61,093	62,038	(945)	(1.5%)
				Revenues				
7,192,160	7,501,725	(309,565)	(4.1%)	Medi-Cal Capitation revenue	29,154,402	30,029,008	(874,606)	(2.9%)
16,201,317	14,841,393	1,359,924	9.2%	Medicare Capitation revenue part C	64,394,728	58,111,159	6,283,569	10.8%
4,535,071	5,314,390	(779,319)	(14.7%)	Medicare Capitation revenue part D	22,151,194	21,626,783	524,411	2.4%
27,928,548	27,657,508	271,040	1.0%	Total Operating Revenue	115,700,324	109,766,950	5,933,374	5.4%
				Medical Expenses				
11,469,777	8,609,924	(2,859,853)	(33.2%)	Provider capitation	45,359,817	33,688,779	(11,671,038)	(34.6%)
2,174,336	5,131,402	2,957,066	57.6%	Facilities	11,287,866	20,280,493	8,992,627	44.3%
505,167	630,062	124,895	19.8%	Ancillary	2,396,687	2,492,303	95,616	3.8%
5,508,982	4,263,497	(1,245,485)	(29.2%)	Long Term Care	20,884,462	16,955,997	(3,928,465)	(23.2%)
5,550,474	5,635,936	85,462	1.5%	Prescription drugs	20,652,922	23,085,901	2,432,979	10.5%
1,061,406	1,198,619	137,213	11.4%	Medical management	4,201,374	4,876,902	675,528	13.9%
156,378	111,015	(45,363)	(40.9%)	Other medical expenses	726,405	456,386	(270,019)	(59.2%)
26,426,520	25,580,455	(846,065)	(3.3%)	Total Medical Expenses	105,509,534	101,836,761	(3,672,773)	(3.6%)
1,502,028	2,077,053	(575,025)	(27.7%)	Gross Margin	10,190,790	7,930,189	2,260,601	28.5%
				Administrative Expenses				
770,831	896,230	125,400	14.0%	Salaries, wages & employee benefits	3,007,829	3,596,351	588,522	16.4%
16,238	38,334	22,097	57.6%	Professional fees	34,613	153,333	118,720	77.4%
(6,492)	239,968	246,460	102.7%	Purchased services	253,272	959,572	706,299	73.6%
108,504	103,801	(4,703)	(4.5%)	Printing and postage	257,222	415,204	157,982	38.0%
44,651	50,149	5,498	11.0%	Other operating expenses	192,533	201,865	9,332	4.6%
664,798	584,428	(80,370)	(13.8%)	Indirect cost allocation, Occupancy Expense	2,659,193	2,337,712	(321,481)	(13.8%)
1,598,529	1,912,910	314,381	16.4%	Total Administrative Expenses	6,404,662	7,664,036	1,259,374	16.4%
				Operating Tax				
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
(96,501)	164,143	(260,644)	(158.8%)	Change in Net Assets	3,786,128	266,153	3,519,975	1322.5%
94.6%	92.5%	(2.1%)	(2.3%)	Medical Loss Ratio	91.2%	92.8%	1.6%	1.7%
5.7%	6.9%	1.2%	17.2%	Admin Loss Ratio	5.5%	7.0%	1.4%	20.7%

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ONECARE CONNECT INCOME STATEMENT – OCTOBER MONTH:

REVENUES of $27.9 million are favorable to budget by $0.3 million driven by:

- Unfavorable volume related variance of $0.5 million due to lower enrollment
- Favorable price related variance of $0.8 million due to fiscal year 2018 rate adjustment

MEDICAL EXPENSES are unfavorable to budget $0.8 million due to:

- Favorable volume related variance of $0.5 million due to lower enrollment
- Unfavorable price related variance of $1.3 million due to increase In-Home Supportive Services (IHSS) expense

ADMINISTRATIVE EXPENSES are favorable to budget by $0.3 million

CHANGE IN NET ASSETS is ($0.1) million, $0.3 million unfavorable to budget

CalOptima - OneCare
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,406	1,344	62	4.6%	Member Months	5,563	5,318	245	4.6%
				Revenues				
71,186	46,687	24,499	52.5%	Medi-Cal Capitation revenue	281,655	184,765	96,890	52.4%
1,449,326	882,281	567,045	64.3%	Medicare Part C Revenue	1,983,907	3,393,383	(1,409,476)	(41.5%)
362,615	481,140	(118,526)	(24.6%)	Medicare Part D Revenue	1,406,945	1,888,222	(481,277)	(25.5%)
1,883,126	1,410,108	473,018	33.5%	Total Operating Revenue	3,672,507	5,466,370	(1,793,863)	(32.8%)
				Medical Expenses				
548,437	387,682	(160,755)	(41.5%)	Provider capitation	(908,166)	1,496,332	2,404,498	160.7%
322,811	449,431	126,620	28.2%	Inpa ient	1,159,321	1,770,475	611,154	34.5%
67,238	48,658	(18,580)	(38.2%)	Ancillary	152,699	191,142	38,443	20.1%
42,128	42,190	62	0.1%	Skilled nursing facilities	94,683	165,128	70,445	42.7%
489,156	486,215	(2,941)	(0.6%)	Prescription drugs	1,910,085	1,908,708	(1,377)	(0.1%)
17,894	21,820	3,927	18.0%	Medical management	69,195	90,871	21,676	23.9%
9,686	7,474	(2,212)	(29.6%)	Other medical expenses	31,035	30,522	(513)	(1.7%)
1,497,350	1,443,470	(53,880)	(3.7%)	Total Medical Expenses	2,508,852	5,653,178	3,144,326	55.6%
385,777	(33,362)	419,139	1256.3%	Gross Margin	1,163,655	(186,808)	1,350,463	722 9%
				Administrative Expenses				
20,264	20,440	176	0.9%	Salaries, wages & employee benefits	95,856	81,521	(14,335)	(17.6%)
0	13,333	13,333	100.0%	Professional fees	0	53,332	53,332	100 0%
10,988	12,040	1,052	8.7%	Purchased services	49,562	48,010	(1,552)	(3 2%)
11,914	19,288	7,374	38.2%	Prin ing and postage	20,486	84,652	64,166	75.8%
(32)	172	204	118.5%	Other operating expenses	(32)	734	766	104.4%
13,553	31,910	18,357	57.5%	Indirect cost allocation, Occupancy Expense	54,212	127,640	73,428	57.5%
56,688	97,183	40,495	41.7%	Total Administrative Expenses	220,084	395,889	175,805	44.4%
329,089	(130,545)	459,634	352.1%	Change in Net Assets	943,571	(582,697)	1,526,268	261 9%
79.5%	102.4%	22.9%	22.3%	Medical Loss Ra io	68.3%	103.4%	35.1%	33.9%

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CalOptima - PACE
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
227	231	(4)	(1.7%)	Member Months	891	894	(3)	(0.3%)
				Revenues				
1,148,054	1,168,004	(19,950)	(1.7%)	Medi-Cal capitation revenue	4,725,359	4,522,000	203,359	4.5%
338,956	278,457	60,499	21.7%	Medicare part C revenue	1,412,993	1,068,469	344,524	32.2%
(11,488)	75,836	(87,324)	(115.1%)	Medicare part D revenue	200,251	291,450	(91,199)	(31.3%)
1,475,522	1,522,297	(46,775)	(3.1%)	Total Operating Revenues	6,338,603	5,881,919	456,684	7.8%
				Medical Expenses				
525,384	591,933	66,549	11.2%	Clinical salaries & benefits	2,054,716	2,324,528	269,812	11.6%
118,668	333,470	214,802	64.4%	Claims payments to hospitals	937,182	1,280,800	343,618	26.8%
366,989	275,404	(91,585)	(33.3%)	Professional Claims	1,341,227	1,057,555	(283,672)	(26.8%)
113,843	115,843	2,000	1.7%	Prescription drugs	442,777	444,995	2,218	0.5%
(88)	11,571	11,659	100.8%	Long-term care facility payments	16,302	47,106	30,804	65.4%
87,959	95,430	7,471	7.8%	Patient Transportation	373,589	366,315	(7,274)	(2.0%)
0	0	0	0.0%	Reinsurance	0	0	0	0.0%
8,000	0	(8,000)	0.0%	Other Expenses	16,000	0	(16,000)	0.0%
1,220,755	1,423,651	202,896	14.3%	Total Medical Expenses	5,181,792	5,521,299	339,507	6.1%
254,767	98,646	156,121	158.3%	Gross Margin	1,156,810	360,620	796,190	220.8%
				Administrative Expenses				
69,869	96,486	26,617	27.6%	Salaries, wages & employee benefits	277,829	373,542	95,713	25.6%
2,213	5,000	2,787	55.7%	Professional fees	11,253	20,000	8,747	43.7%
3,990	21,136	17,146	81.1%	Purchased services	16,414	84,544	68,130	80.6%
183	5,547	5,364	96.7%	Printing and postage	5,178	22,188	17,010	76.7%
2,168	2,052	(116)	(5.7%)	Depreciation & amortization	8,600	8,208	(392)	(4.8%)
17,417	18,506	1,089	5.9%	Other operating expenses	71,303	74,018	2,715	3.7%
3,052	2,864	(188)	(6.6%)	Indirect cost allocation, Occupancy Expense	34,396	11,456	(22,940)	(200.2%)
98,893	151,591	52,698	34.8%	Total Administrative Expenses	424,974	593,956	168,982	28.5%
				Operating Tax				
3,169	0	3,169	0.0%	Tax Revenue	28,126	0	28,126	0.0%
3,169	0	(3,169)	0.0%	Premium tax expense	28,126	0	(28,126)	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
155,874	(52,945)	208,819	394.4%	Change in Net Assets	731,837	(233,336)	965,173	413.6%
82.7%	93.5%	10.8%	11.5%	Medical Loss Ratio	81.7%	93.9%	12.1%	12.9%
6.7%	10.0%	3.3%	32.7%	Admin Loss Ratio	6.7%	10.1%	3.4%	33.6%

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CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
27,825	0	27,825	0.0%	Rental income	103,762	42,774	60,988	142.6%
27,825	0	27,825	0.0%	Total Operating Revenue	103,762	42,774	60,988	142.6%
				Administrative Expenses				
29,467	23,186	(6,282)	(27.1%)	Purchase services	118,040	92,744	(25,296)	(27.3%)
159,543	161,474	1,930	1.2%	Depreciation & amortization	638,844	645,895	7,051	1.1%
14,913	9,117	(5,797)	(63.6%)	Insurance expense	59,653	36,467	(23,186)	(63.6%)
123,462	158,122	34,659	21.9%	Repair and maintenance	455,924	632,486	176,562	27.9%
85,768	0	(85,768)	0.0%	Other Operating Expense	245,953	0	(245,953)	0.0%
(390,466)	(333,055)	57,411	17.2%	Indirect allocation, Occupancy Expense	(1,435,033)	(1,332,220)	102,814	7.7%
22,688	18,843	(3,845)	(20.4%)	Total Administrative Expenses	83,381	75,372	(8,009)	(10.6%)
5,137	(18,843)	23,980	127.3%	Change in Net Assets	20,381	(32,598)	52,979	162.5%

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OTHER STATEMENTS – OCTOBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $329.1 thousand, $459.6 thousand favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $155.9 thousand, $208.8 thousand favorable to budget

505 CITY PARKWAY BUILDING INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $5.1 thousand, $24.0 favorable to budget

CalOptima
BALANCE SHEET
October 31, 2017

ASSETS			**LIABILITIES & FUND BALANCES**	
Current Assets			Current Liabilities	
	Operating Cash	$595,875,265	Accounts payable	$26,835,297
	Investments	893,957,195	Medical claims liability	1,052,927,427
	Capitation receivable	348,723,749	Accrued payroll liabilities	12,213,097
	Receivables - Other	24,107,561	Deferred revenue	156,624,497
	Prepaid Expenses	4,326,372	Deferred lease obligations	178,046
			Capitation and withholds	445,423,990
	Total Current Assets	**1,866,990,142**	**Total Current Liabilities**	**1,694,202,355**
Capital Assets	Furniture and equipment	34,039,048	Other employment benefits liability	29,281,263
	Building/Leasehold improvements	5,883,665		
	505 City Parkway West	49,433,337	Net Pension Liabilities	16,279,542
		89,356,051	Long Term Liabilities	100,000
	Less: accumulated depreciation	(37,039,357)		
	Capital assets, net	**52,316,694**	**TOTAL LIABILITIES**	**1,739,863,160**
Other Assets	Restricted deposit & Other	300,000	Deferred inflows of Resources - Excess Earnings	-
			Deferred inflows of Resources - Changes in Assumptions	1,340,010
	Board-designated assets			
	Cash and cash equivalents	23,993,088	Tangible net equity (TNE)	89,267,130
	Long term investments	513,303,463	Funds in excess of TNE	638,010,227
	Total Board-designated Assets	537,296,552		
	Total Other Assets	**537,596,552**	**Net Assets**	**727,277,357**
	Deferred outflows of Resources - Pension Contributions	5,234,198		
	Deferred outflows of Resources - Difference in Experience	1,072,771		
	Deferred outflows of Resources - Excess Earnings	5,270,171		
TOTAL ASSETS & OUTFLOWS		**2,468,480,527**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,468,480,527**

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CalOptima
Board Designated Reserve and TNE Analysis
as of October 31, 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,818,562				
	Tier 1 - Logan Circle	146,605,875				
	Tier 1 - Wells Capital	146,501,667				
Board-designated Reserve		439,926,104	307,284,558	477,235,282	132,641,546	(37,309,178)
TNE Requirement	Tier 2 - Logan Circle	97,370,448	89,267,130	89,267,130	8,103,317	8,103,317
	Consolidated:	537,296,552	396,551,688	566,502,412	140,744,863	(29,205,861)
	Current reserve level	*1.90*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
October 31, 2017

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	2,510,218	13,818,965
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	532,695	2,391,028
Changes in assets and liabilities:		
Prepaid expenses and other	651,845	1,328,275
Catastrophic reserves		
Capitation receivable	37,780,768	170,717,425
Medical claims liability	(369,942,872)	(193,498,593)
Deferred revenue	(349,285)	52,651,372
Payable to providers	7,489,173	(135,415,721)
Accounts payable	8,340,299	(10,715,981)
Other accrued liabilities	495,891	1,524,966
Net cash provided by/(used in) operating activities	(312,491,269)	(97,198,263)
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	147,397,848	188,468,557
Change in property and equipment	(304,200)	(406,695)
Change in Board designated reserves	(205,757)	(2,158,178)
Net cash provided by/(used in) investing activities	146,887,892	185,903,684
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(165,603,377)	88,705,420
CASH AND CASH EQUIVALENTS, beginning of period	$761,478,642	507,169,844
CASH AND CASH EQUIVALENTS, end of period	**$ 595,875,265**	**$ 595,875,265**

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BALANCE SHEET:

ASSETS decreased $351.5 million from September

- **Cash and Cash Equivalents** decreased by $165.6 million due to disbursements for Quality Assurance Fees (QAF) and Intergovernmental Transfer (IGT)
- **Investments** decreased $147.4 million due to disbursements for Quality Assurance Fees (QAF) and Intergovernmental Transfer (IGT)
- **Net Capitation Receivables** decreased $37.1 million based upon payment receipt timing and receivables

LIABILITIES decreased $354.0 million from September

- **Medical Claims Liability** by line of business decreased $370.0 million due to disbursements for Quality Assurance Fees (QAF) and Intergovernmental Transfer (IGT)
- **Capitation Payable** increased $7.5 million due to timing of payments
- **Accrued Expenses** increased $7.2 million due to timing of payments

NET ASSETS are $727.3 million, an increase of $2.5 million from September

CalOptima Foundation
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2017
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	0	0	0.0%	Total Operating Revenue	0	0	0	0.0%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	0	24,737	24,737	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	11,939	11,939	100.0%
0	0	0	0.0%	Travel	0	0	0	0.0%
0	0	0	0.0%	Supplies	0	0	0	0.0%
0	0	0	0.0%	Contractual	0	0	0	0.0%
2,083	231,923	229,840	99.1%	Other	8,332	927,692	919,360	99.1%
2,083	241,092	239,009	99.1%	Total Operating Expenditures	8,332	964,368	956,036	99.1%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
(2,083)	(241,092)	(239,009)	(99.1%)	Program Income	(8,332)	(964,368)	(956,036)	(99.1%)

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CalOptima Foundation
Balance Sheet
October 31, 2017

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,868,139	Accounts payable-Current	8,332
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,868,139**	Grants-Foundation	0
		Total Current Liabilities	8,332
		Total Liabilities	**8,332**
		Net Assets	**2,859,807**
TOTAL ASSETS	**2,868,139**	**TOTAL LIABILITIES & NET ASSETS**	**2,868,139**

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CALOPTIMA FOUNDATION - OCTOBER MONTH

INCOME STATEMENT:

OPERATING REVENUE

- No activity

OPERATING EXPENSES

- Audit Fees $2.0 thousand

BALANCE SHEET:

ASSETS

- Cash--$2.9 million remains from the FY14 $3.0 million transferred by CalOptima for grants and programs in support of providers and community

LIABILITIES

- Accrued Payables--$8.3 thousand for Audit fees

NET INCOME is ($8.3) thousand

Budget Allocation Changes
Reporting Changes for October 2017

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	IS - Infrastructure - Professional Fee (Virtualization Architecture Assessment)	IS - Infrastructure - Professional Fee (On-Site Staff for the Phone System)	$48,600	Re-Purpose $48,600 from Professional Fees (Virtualization Architecture Assessment) to pay for an on-site staff for the phone system	2018
July	Medi-Cal	Facilities - Purchased Services (Restacking Services)	Facilities - Purchased Services (Reconfiguration Services)	$15,000	Re-Purpose $15,000 from Purchased Services (Restacking Services) to reconfiguration and breakdown of furniture for the mail room and the Rover Rock Offices and other related expenses	2018
August	Medi-Cal	Health Educa ion & Disease Mgmt. - Purchased Services (Adult Weight Management Vendor)	Health Education & Disease Mgmt. - Purchased Services (Ansafone)	$30,000	Re-Purpose $30,000 from Purchased Services (Adult Weight Management Vendor) to pay for Ansafone services	2018
August	Medi-Cal	Health Educa ion & Disease Mgmt. - Purchased Services (Pediatric Weight Management Vendor)	Health Education & Disease Mgmt. - Purchased Services (Captivate contract and o her initiatives)	$25,000	Re-Purpose $25,000 from Purchased Services (Pediatric Weight Management Vendor) to pay for Captivate contract and other initiatives	2018
August	PACE	PACE Administrative - Purchased Services (Encounter Reporting & Translation Services)	PACE Administrative - Purchased Services (Satisfaction Survey)	$12,208	Re-Purpose $12,208 from Purchased Services (Encounter Reporting & Translation Services) to pay for Satisfaction Survey	2018
August	Medi-Cal	Facilities - Capital Project (Upgrade CalOptima and Building Access System)	Facilities - Capital Project (Mail Room/Basement/ Property Management Office)	$15,000	Reallocate $15,000 from Capital Project (Upgrade CalOptima and Building Access System) to Capital Project (Mail Room/Basement/Property Management Office)	2018
September	Medi-Cal	Other G&A - Other Operating Expenses	Facilities - Building Repair and Maintenance	$65,000	Reallocate $65,000 from Other G&A (o her operating expenses) to cover cost to conduct a review/study from soil engineer and he necessary repairs of the east entry sinkhole.	2018
September	OCC	Health Educa ion & Disease Management - Member Communications	Health Education & Disease Management - Purchased Services	$12,000	Reallocate $12,000 within medical management activities budget for additional funding needed on CareNet in OneCare Connect.	2018

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Board of Directors Meeting
December 7, 2017

Monthly Compliance Report

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

A. Updates on Regulatory Audits

1. OneCare

- 2016 CMS Financial Audit:

  On August 24, 2017, the Centers for Medicare & Medicaid Services (CMS) notified CalOptima that its OneCare program has been selected for a 2016 financial audit. By way of background, at least one-third of Medicare Advantage Organizations (MAOs) are selected for CMS' annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CMS contracted with Bland & Associates to conduct the review of claims data, solvency, enrollment, base year entries on the bids, medical and/or drug expenses, related party transactions, general administrative expenses, and direct and indirect remuneration (DIR). On October 24, 2017, Bland & Associates held a pre-conference meeting with CalOptima to discuss the expectations of the audit and to provide an opportunity for CalOptima to ask any questions related to the audit process and documentation request. The onsite audit date(s) have yet to be determined.

2. OneCare Connect

- 2017 Performance Measure Validation (PMV) Activity:

  On July 7, 2017, CalOptima received an engagement letter from CMS' contractor, Health Services Advisory Group, Inc. (HSAG), for a performance measure validation (PMV) activity of select core and state-specific reporting measures for Medicare-Medicaid Plans (MMPs). On September 18, 2017, HSAG validated the data collection and reporting processes used by CalOptima to report the health risk assessment and interdisciplinary care plan completion rates for our OneCare Connect membership. CalOptima is currently pending results from HSAG.

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- CMS Universe Integrity Testing (applicable to OneCare Connect and OneCare):

  In August 2017, CalOptima's Office of Compliance began conducting Universe Integrity Testing to validate the completeness and accuracy of all universes required for submission during a CMS program audit for OneCare and OneCare Connect to ensure audit readiness. Specifically, CalOptima's Office of Compliance began validating the completeness and accuracy of all universes in accordance with the final 2017 CMS Medicare Parts C and D Program Audit Protocols and the 2017 CMS Program Audit Pilot Protocols for Medicare-Medicaid Plans (MMPs). CalOptima's Office of Compliance has completed the Universe Integrity Testing, and is in the process of working with internal business areas and delegates to remediate the universe issues.

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

  CalOptima is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis, and to share the results with its governing body. As such, CalOptima has engaged an independent auditor to conduct the audit to ensure that its Compliance Program is administering the elements of an effective compliance program as outlined in the CMS Medicare Parts C and D Program Audit Protocols. The onsite audit took place from November 6 – 9, 2017. CalOptima is currently pending results from the independent auditor.

3. Medi-Cal

- Department of Managed Health Care (DMHC) 1115 Waiver Seniors and Persons with Disabilities (SPDs) Audit:

  The DMHC conducted its tri-annual audit of CalOptima's Medi-Cal SPDs from February 6-10, 2017. The DMHC conducted the audit on behalf of the DHCS as part of an inter-agency agreement. The audit covered the period from November 1, 2014 through October 31, 2016. On July 27, 2017, DHCS sent CalOptima a report regarding the audit, which identified ten (10) deficiencies in the areas of utilization management, continuity of care, availability and accessibility, member rights, and quality management. Following CalOptima's submission of a Corrective Action Plan (CAP), CalOptima received notification on 11/2/17 that all audit deficiencies have been reviewed and closed with no further action necessary.

4. PACE

- 2017 DHCS PACE Level of Care Audit:

  On October 26, 2017, CalOptima PACE successfully completed and passed the 2017 Department of Health Care Services (DHCS) PACE Level of Care (LOC) audit. The

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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review period was October 2016 through March 2017. No findings were reported during the audit.

B. Regulatory Notices of Non-Compliance

1. CalOptima did not receive any notices of non-compliance from its regulators for the month of November 2017.

C. Updates on Internal and Health Network Audits

1. Internal Audits: Medi-Cal [a\]

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

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
June 2017	40%	N/A	N/A	0%	10%	93%	98%	100%	67%	89%	100%	33%	100%
July 2017	60%	N/A	N/A	0%	93%	87%	94%	100%	80%	90%	Nothing to Report	Nothing to Report	Nothing to Report
August 2017	40%	N/A	N/A	0%	0%	73%	90%	70%	90%	93%	0%	67%	76%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent – 72 Hours; Routine – 5 business days; Deferral– 14 business days)
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)

- The lower scores for clinical decision making were due to the following reason:
  - Failure to cite criteria for decision

- The lower letter scores were due to the following reason:
  - Failure to describe why the request did not meet criteria in lay language

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 Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2017	100%	100%	100%	100%
July 2017	100%	100%	100%	90%
August 2017	100%	90%	100%	90%

  - The compliance rate for paid claims accuracy has decreased from 100% in July 2017 to 90% in August 2017 due to an incorrect rate being utilized when processing payment for claims.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Letter Accuracy	Determination Timeliness	Acknowledgement Timeliness
June 2017	100%	100%	100%
July 2017	100%	75%	100%
August 2017	100%	100%	90%

  - The compliance rate for acknowledgement timeliness has decreased from 100% in July 2017 to 90% in August 2017 due to PDR acknowledgment letters not being sent timely.

- Medi-Cal Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	Medi-Cal Call Center	Member Liaison Call Center
June 2017	100%	98%
July 2017	99%	100%
August 2017	98%	100%

  - The compliance rate for the Medi-Cal call center has decreased from 99% in July 2017 to 98% in August 2017 due to incomplete documentation on calls.

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 Audits: OneCare

- OneCare Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
June 2017	0%
July 2017	0%
August 2017	0%

  - No claims were rejected in error due to formulary restrictions from June through August 2017.

- OneCare Pharmacy: Coverage determination timeliness is reviewed on a monthly basis to ensure that coverage determinations are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
June 2017	100%
July 2017	100%
August 2017	100%

  - The compliance rate for coverage determination timeliness remains consistent at 100% from June through August 2017.

- OneCare Utilization Management

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making (CDM) for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	CDM for Denials	Letter Score for Denials
June 2017	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
July 2017	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
August 2017	Nothing to Report	Nothing to Report	Nothing to Report	100%	0%	Nothing to Report	Nothing to Report	Nothing to Report

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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- Due to low membership for the months of June 2017 through August 2017, there were no denials or expedited organization determinations reported for this time period.

- The lower letter scores were due to the following reason:
  - Failure to use the approved CMS letter template
  - Failure to use the CalOptima logo

- OneCare Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2017	100%	100%	100%	100%
July 2017	100%	100%	100%	89%
August 2017	90%	90%	100%	100%

- The compliance rate for paid claims timeliness has decreased from 100% in July 2017 to 90% in August 2017 due to claims processed untimely.

- The compliance rate for paid claims accuracy has decreased from 100% in July 2017 to 90% in August 2017 due to interest not being applied to claim.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
June 2017	100%	100%	100%	100%
July 2017	50%	100%	100%	100%
August 2017	100%	100%	100%	100%

- No significant trends to report.

- OneCare Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Customer Service
June 2017	100%
July 2017	99%
August 2017	100%

- No significant trends to report.

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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3. Internal Audits: OneCare Connect [a\]

- OneCare Connect Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
June 2017	0%
July 2017	0%
August 2017	0%

  - ➢ No claims were rejected in error due to formulary restrictions from June through August 2017.

- OneCare Connect Pharmacy: Coverage determination timeliness is reviewed on a monthly basis to ensure that coverage determinations are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
June 2017	100%
July 2017	100%
August 2017	100%

  - ➢ No significant trends to report.

- OneCare Connect Utilization Management: Prior Authorization (PA) 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 Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
June 2017	78%	N/A	61%	0%	50%	80%	67%	89%	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
July 2017	80%	N/A	100%	70%	95%	70%	67%	89%	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
August 2017	80%	N/A	50%	80%	15%	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - ➢ The lower letter scores were due to the following reasons:
    - Failure to provide letter in member preferred language
    - Failure to provide language assistance program (LAP) insert with approved threshold languages
    - Failure to provide description of services in lay language

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 and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2017	90%	100%	100%	100%
July 2017	80%	100%	100%	90%
August 2017	100%	100%	100%	90%

  - No significant trends to report.

- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
June 2017	100%	100%	100%	100%
July 2017	95%	100%	100%	100%
August 2017	100%	100%	100%	100%

  - No significant trends to report.

- OneCare Connect Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Connect Customer Service
June 2017	100%
July 2017	100%
August 2017	100%

  - No significant trends to report.

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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4. Internal Audits: PACE

- PACE Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2017	100%	100%	100%	100%
July 2017	90%	100%	100%	100%
August 2017	100%	100%	100%	86%

  - The compliance rate for denied claims accuracy has decreased from 100% in July 2017 to 86% in August 2017 due to unclean claims not being developed.

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check LAG
June 2017	100%	100%	100%	100%
July 2017	100%	100%	67%	N/A
August 2017	100%	100%	100%	100%

  - No significant trends to report.

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

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

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
June 2017	85%	84%	89%	77%	84%	87%	92%	88%	100%	100%	54%	34%	41%
July 2017	74%	100%	84%	73%	67%	83%	89%	100%	92%	89%	78%	33%	56%
August 2017	63%	79%	85%	61%	55%	85%	81%	70%	92%	97%	65%	89%	60%

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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- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent – 72 Hours; Routine – 5 business days; Deferral– 14 business days)
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)
  - Failure to meet timeframe for member delay notification (2 business days)
  - Failure to meet timeframe for provider delay notification (2 business days)

- The lower scores for clinical decision making (CDM) were due to the following reasons:
  - Failure to obtain adequate clinical information
  - Failure to have appropriate professional make decision
  - Failure to use criteria for decision

- The lower letter scores were due to the following reasons:
  - Failure to provide information on how to file a grievance
  - Failure to provide letter in member preferred language
  - Failure to provide language assistance program (LAP) insert with approved threshold languages
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide description of services in lay language
  - Failure to provide alternative direction back to PCP on denial
  - Failure to provide name and contact information for health care professional responsible for decision to requesting provider
  - Failure to provide peer-to-peer discussion with medical reviewer

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2017	100%	99%	98%	95%
July 2017	100%	100%	100%	92%
August 2017	97%	99%	99%	87%

- The compliance rate for paid claims timeliness decreased from 100% in July 2017 to 97% in August 2017 due to untimely processing of claims.

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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- The compliance rate for paid claims accuracy decreased from 100% in July 2017 to 99% in August 2017 due to an incorrect received date used when processing claims.

- The compliance rate for denied claims timeliness decreased from 100% in July 2017 to 99% in August 2017 due to untimely processing of claims.

- The compliance rate for denied claims accuracy decreased from 92% in July 2017 to 87% in August 2017 due to emergency room claims being denied incorrectly.

- Medi-Cal Claims: Misclassified Hospital Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
June 2017	99%	99%
July 2017	100%	98%
August 2017	100%	100%

- No significant trends to report.

- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2017	100%	100%	100%	100%
July 2017	100%	100%	100%	100%
August 2017	100%	100%	100%	100%

- No significant trends to report.

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. Health Network Audits: OneCare [a\]

- OneCare Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making (CDM) for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	CDM for Denials	Letter Score for Denials
June 2017	100%	N/A	77%	89%	70%	67%	56%	92%
July 2017	83%	100%	78%	88%	84%	67%	56%	90%
August 2017	86%	100%	72%	87%	76%	67%	56%	88%

  - The lower scores for timeliness were due to the following reasons:
    - Failure to meet timeframe for decision making (Expedited – 72 hours)
    - Failure to meet timeframe for member oral and written notifications (Expedited – 72 hours)
    - Failure to meet timeframe for provider notifications (Expedited – 72 hours)

  - The lower letter scores were due to the following reasons:
    - Failure to describe why the request did not meet criteria in lay language
    - Failure to provide description of requested services in lay language
    - Failure to use CMS approved template

- OneCare Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
June 2017	100%	99%
July 2017	100%	100%
August 2017	100%	98%

  - The compliance rate for misclassified denied claims decreased from 100% in July 2017 to 98% in August 2017 due to a duplicate claim being inappropriately included in the universe.

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
June 2017	100%	100%	100%	84%
July 2017	100%	99%	100%	95%
August 2017	100%	100%	100%	96%

  - ➢ No significant trends to report.

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

- OneCare Connect Utilization Management (UM): Prior Authorization (PA) 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	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
June 2017	88%	100%	83%	82%	81%	51%	71%	79%	0%	N/A	38%	50%	100%	64%
July 2017	78%	100%	75%	78%	78%	51%	70%	79%	0%	N/A	38%	100%	N/A	38%
August 2017	66%	75%	75%	66%	73%	54%	75%	82%	0%	N/A	38%	Nothing to Report	Nothing to Report	Nothing to Report

- ➢ The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent – 72 Hours; Routine – 5 business days)
  - Failure to meet timeframe for member notifications (2 business days)
  - Failure to meet timeframe for provider initial notifications (24 hours)
  - Failure to provide proof of successful written notification to requesting provider (2 business days)
  - Failure to meet timeframe for member delay notifications (2 business days)
    Failure to meet timeframe for provider delay notifications (2 business days)

- ➢ The lower scores for clinical decision making (CDM) were due to the following reasons:
  - Failure to obtain adequate clinical information
  - Failure to have appropriate professional make decision
  - Failure to use criteria for decision

- ➢ The lower letter scores were due to the following reasons:
  - Failure to provide letter in member preferred language
  - Failure to provide description of services in lay language
  - Failure to provide peer-to-peer discussion with medical reviewer

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: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
June 2017	100%	99%
July 2017	100%	96%
August 2017	99%	90%

  - The compliance rate for misclassified paid claims decreased from 100% in July 2017 to 99% in August 2017 due to a denied claim that should have been excluded from the universe.

  - The compliance rate for misclassified denied claims decreased from 96% in July 2017 to 90% in August 2017 due to a duplicate claim that should have been excluded from the universe.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2017	95%	95%	100%	94%
July 2017	99%	97%	100%	97%
August 2017	97%	95%	98%	87%

  - The compliance rate for paid claims timeliness decreased from 99% in July 2017 to 97% in August 2017 due to an incorrect received date used when processing claims.

  - The compliance rate for paid claims accuracy decreased from 97% in July 2017 to 95% in August 2017 due to an adjusted claim processed as a clean claim.

  - The compliance rate for denied claims timeliness decreased from 100% in July to 98% in August 2017 due to an incorrect received date used when processing claims.

  - The compliance rate for denied claims accuracy decreased from 97% in July to 87% in August 2017 due to claims being denied in error.

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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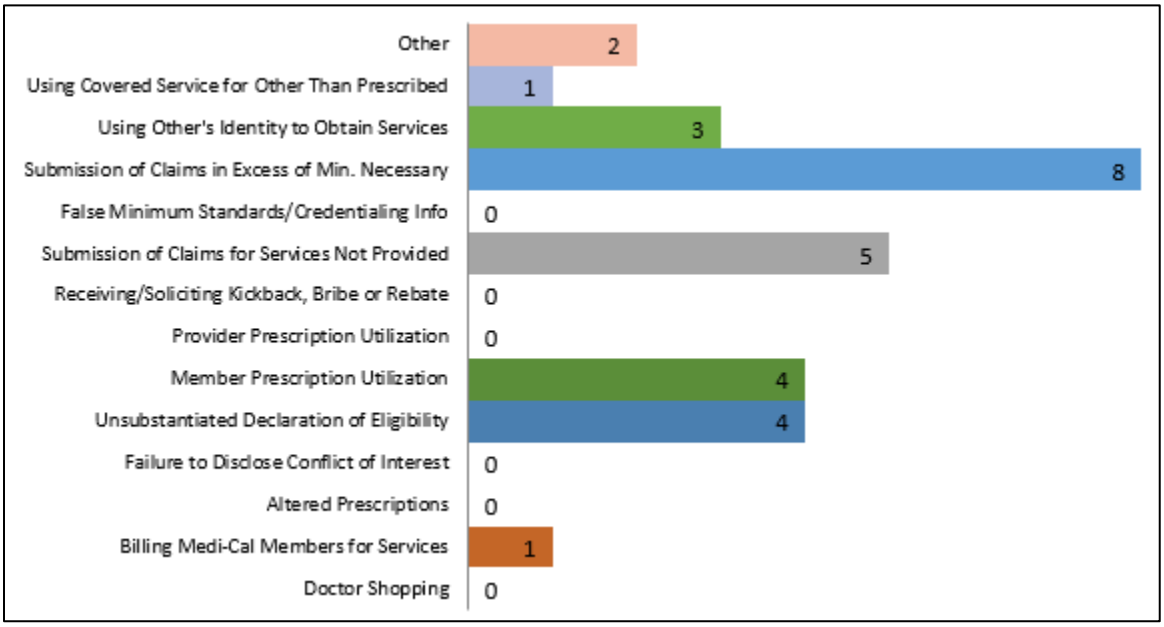
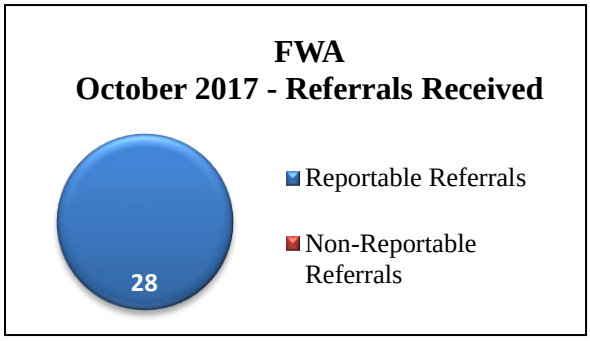
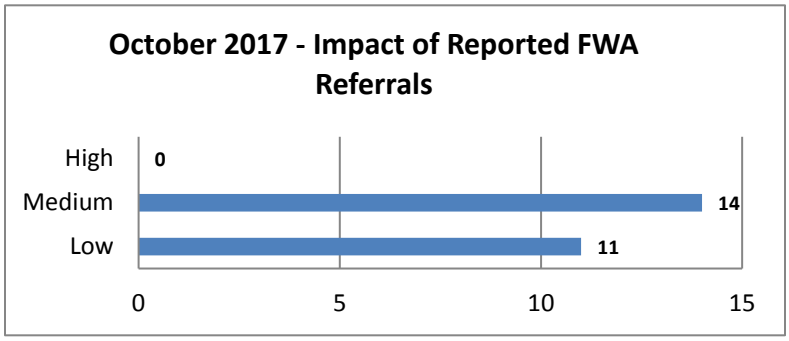
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations (October 2017)

Types of FWA Cases: (Received in October 2017)







Note: For three (3) of the referrals made in October 2017, there was not enough information provided to conduct a risk assessment.

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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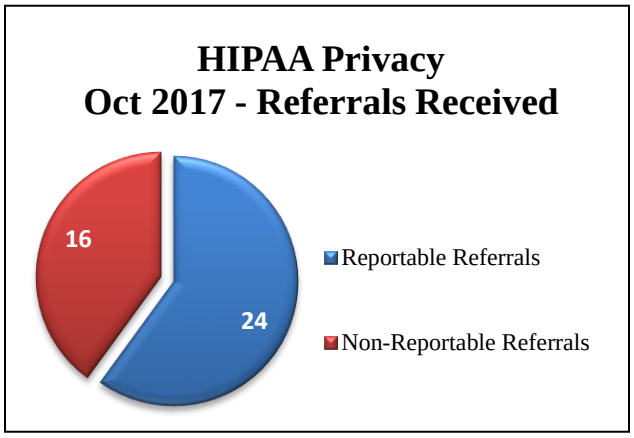
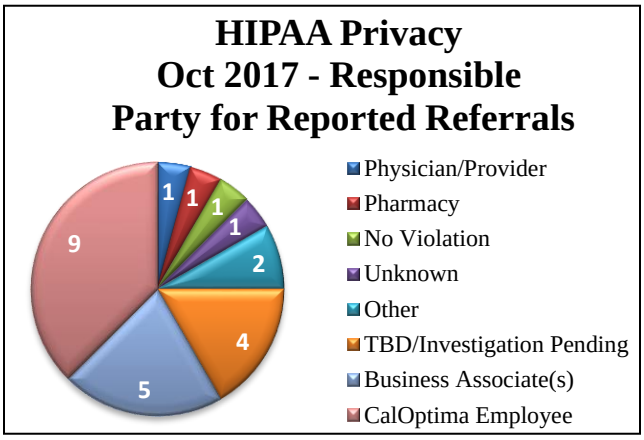
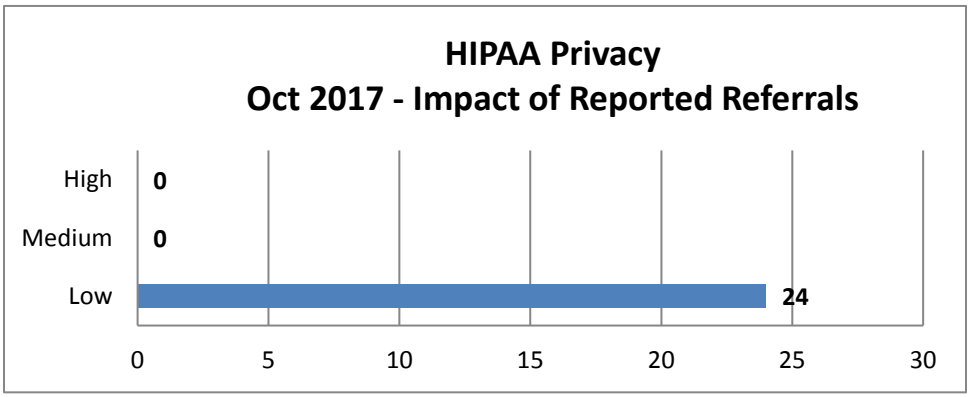
E. Privacy Update (October 2017)







PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	22
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	2
Total Number of Referrals Reported	**24**

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

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CalOptima
A Public Agency
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Federal & State Legislative Advocate Reports

Board of Directors Meeting
December 7, 2017

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

November 13, 2017

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: December Board of Directors Report

In recent weeks, health care policy on Capitol Hill moved behind closed doors as Democrats and Republicans sought to reach a deal to extend funding for the Children's Health Insurance Program (CHIP) and the cost-sharing reduction payments for individuals with marketplace plans. Only minor progress was made in pushing either priority through Congress despite bipartisan agreement on the actual policy. Health care plans, providers, and patient advocacy groups are now eyeing must-pass legislation in December to carry these bills to the President's desk. The following summary reviews these developments from October 9 through November 13.

Children's Health Insurance Program (CHIP) Funding
As previously reported, federal funding for CHIP expired on September 30. However, Congress missed this 'soft' deadline with the knowledge that states could continue to use their existing federal allotment until it is exhausted. Several states are expected to exhaust their funding before the end of the year, while California is expected to exhaust its funding in January. To prevent coverage losses and/or significant state budget shortfalls, the Centers for Medicare and Medicaid Services (CMS) distributed funds left over from an earlier period to those states in emergency situations, including California which received an emergency funding infusion of $177 million on October 12.

On October 4, 2017, both the House and Senate committees with jurisdiction over Medicaid passed bills to extend CHIP funding. The bills contained the same CHIP policy, but differed on how to pay for the extended funding. Both House and Senate bills would:

- extend federal CHIP funding for 5 years through FY2022;
- keep the maintenance of effort requirements through FY2022, preventing states from restricting CHIP eligibility beyond what was in place in 2010; and
- phase-down the 23 percent funding "bump" according to the following schedule:

Year	Bump
FY2018	23%
FY2019	23%
FY2020	11.5%
FY2021	0%
FY2022	0%

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The Senate bill reported out of the Finance Committee did not include provisions to reduce spending or raise revenue in order to pay for the additional CHIP funding. Chairman Orrin Hatch (R-UT) and Ranking Member Ron Wyden (D-OR) agreed to continue working on the offsets as they push the bill to the floor.

The House bill reported out of the Energy and Commerce Committee included provisions to pay for the CHIP funding that only Republicans supported despite weeks of negotiations with the committee's leading Democrats. As a result, the bill passed out of Committee on a straight party line vote with all Republicans voting for passage and all Democrats voting against it, foreshadowing a break from the long tradition of bipartisan support for CHIP.

Following the October 4 committee markup, Republicans and Democrats in the House returned to the negotiating table to try to reach an agreement on how to pay for the additional CHIP funding. These talks dragged on for several weeks with the Chairman Greg Walden (R-OR) and Ranking Member Frank Pallone (D-NJ) trading public statements about who was to blame for the expiration of CHIP funding. Without a deal in sight and the end of the year rapidly approaching, the Republican majority sought to push the bill forward. On Thursday, October 26, House Majority Whip Kevin McCarthy (R-CA-23) announced that a vote to extend CHIP funding would take place the following week.

The bill that the Republicans put on the floor actually combined two bills passed out of the Energy and Commerce Committee. The Championing Healthy Kids Act (HR3922) included provisions to:

- *CHIP Policy*: extend for 5 years federal CHIP funding, phase-down of the additional 23% "bump," keep the maintenance-of-effort requirements for the 5 year period of the funding extension, and require that mental health services be covered for CHIP enrollees;
- *Community Health Centers*: extend for 2 years federal funding for community health centers;
- *Other health programs*: extend for 2 years federal funding for the National Health Service Corps, Teaching Health Center Graduate Medical Education, Family-to-Family Health Information Centers, and the Personal Responsibility Education Program;
- *Hurricane aid*: provide $1 billion in Medicaid funding for Puerto Rico and the US Virgin Islands to "shore up" the Medicaid programs in those territories following the recent hurricanes; and
- *Hospital cuts delayed*: delay for 2 years planned reimbursement cuts to hospitals that cover a disproportionate share of the uninsured.

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In order to pay for the above policies, the bill included the same provisions that Democrats objected to in committee, which would:

- *Third party liability*: no longer require states to pay Medicaid claims for prenatal care, preventive pediatric care, and for individuals on whose behalf child support enforcement is being conducted where the patient has third party coverage (current law requires states to pay these claims within 30 days even if the patient has third party coverage);
- *Disenrollment for lottery winners*: count lump-sum payments in excess of $80,000 as income over the course of many months rather than a single month, preventing individuals who receive such payments from re-enrolling in Medicaid following the receipt of such payments;
- *Prevention and Public Health Fund*: reduce spending by the Public Health and Prevention Fund;
- *Medicare premiums*: require Medicare beneficiaries with annual income over $500,000 to be fully responsible for their Part B and D premiums (current law requires these seniors to pay 80% of their premiums with the rest covered by federal subsidies); and
- *Marketplace grace periods*: shorten the grace period for missed payments on marketplace insurance plans from 90 days to 30 days unless the state chooses a different period.

With little change to the offsets, Democrats largely opposed this bill when it finally came to a vote on November 3. Out of over 180 House Democrats, only 15, including Orange County Representative Luis Correa (D-CA-46), voted for the bill.

Hopes for CHIP funding now shift to the Senate, where the Republican majority will need Democratic support to overcome the 60 vote threshold for passage, forcing a bipartisan compromise on how to pay for the bill. Given the limited number of days available on the Senate floor calendar between now and the end of the year plus the Republican Party's focus on tax reform, the most likely avenue for passing CHIP funding is not as a standalone bill but rather to attach it to another piece of must-pass legislation. These legislative 'vehicles' that CHIP funding could 'ride' with include a rumored third disaster supplemental spending package or general government funding to avoid a shutdown when current funding expires on December 8.

Affordable Care Act Update
Although Republicans have largely moved on from attempting to repeal and replace the Affordable Care Act, the party remains split on whether to try to make it work or whether it should try to repeal key, unpopular pieces of it.

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President Trump is firmly in the latter camp. On October 12, his administration announced it would not make cost-sharing reduction reimbursement payments to insurance companies for the co-pays, co-insurance, and deductibles the ACA requires the companies cover for lower- and middle-income Americans on marketplace plans. For several years, House Republicans pursued a lawsuit to prevent the Obama Administration from making these payments, pointing to a drafting error that authorized the payments but did not appropriate the funding. The Obama administration made the payments anyway, arguing that it had the executive authority to fulfill the clear intention of the law. The insurance companies relied on the reimbursement of these payments, and threatened that monthly premiums would increase dramatically without them. After taking office, the Trump Administration refused to commit to making these payments more than a month in advance, creating great uncertainty in the individual marketplaces.

Others in his party, however, disagree. They generally believe two things about the current health care politics and policy dynamic: First, that as the majority party in control of both the legislature and executive branch, Republicans will be held accountable in the midterm elections for the success or failure of the health care system, and, second, making the payments will lead to lower premiums for consumers. The leader of this faction is Senator Lamar Alexander (R-TN), who also happens to be the Chairman of the Senate Committee on Health, Education, Labor, and Pensions (HELP), which has jurisdiction over the individual insurance marketplaces.

Senator Alexander negotiated a deal with the most senior Democrat on the committee, Senator Patty Murray (D-WA), to make these payments in 2018 and 2019. In return, Republicans would get further flexibility and speed for states to make changes to the marketplace plans in their states, but without undermining the ACA's key consumer protections. The Alexander-Murray deal was announced on October 17. Two days later, they announced on the Senate floor that their bill had the support of 22 cosponsors – 11 Democrats and 11 Republicans. Of course, the assumption is that every Senate Democrat supports the deal and with these additional Republican cosponsors, the deal has the support of 60 Senators, a filibuster-proof majority. While having the votes is a significant show of political force, it is still short of actually getting a vote. Majority Leader Mitch McConnell (R-KY) indicated that he would put the bill up for a vote if it was supported by the President. Unfortunately, his position on the deal changed several times in the hours and days following its announcement. Ultimately, President Trump refused to support it. Like many other agenda items, this too will have to wait to be resolved in a must-pass end-of-year spending package. It is assumed that Senate Democrats, whose votes will again be needed to keep the government open past December 8, will demand, among other items, the cost-sharing reduction payments as part of a deal.

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In the meantime, the camp within the Republican Party that is seeking to undermine the ACA continues to look for such opportunities. For instance, President Trump and conservative House and Senate Republicans have proposed that the individual mandate be repealed as part of the ongoing tax reform negotiations. The Republican chairmen of the House and Senate tax writing committees have so far refused this demand out of fear that importing a controversial health care matter into tax policy could sink the whole endeavor. Yet, it remains an attractive mechanism for raising revenue to pay for the bill's tax cuts since CBO said repealing the individual mandate would save roughly $338 billion in federal premium subsidies for the 13 million people who would become uninsured.

Conclusion

In the cases of both the CHIP funding and the CSR payments, there is bipartisan agreement on the underlying policy. Yet, in both cases, broader health care politics and a clogged Congressional agenda have come together to force both of these key items to wait until the end of the year when an even bigger deadline will force Congress to act.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

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CALOPTIMA LEGISLATIVE REPORT
By Don Gilbert and Trent Smith
November 9, 2017

Legislators are back in their districts until after the New Year. With the exception of some information hearings, the State Capitol will remain very quiet until Legislators return.

Since our last report, a handful of bills were signed into law by Governor Brown. Among them was SB 17 by Senator Hernandez. This measure requires drug manufacturers to notify specified purchasers in writing, at least 90 days prior to the planned effective date, if it is increasing a drug price by more than 16 percent over a two-year period. The bill also requires health plans and insurers that report rate information through the existing large and small group rate review process to also report specified information related to prescription drug pricing to the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). These agencies would then be required to prepare a consumer-friendly report that demonstrates the overall impact of drug costs on health care premiums.

SB 17 was supported by labor unions and commercial health plans that are concerned with the high costs of prescription drugs and the impact they have on the overall rising costs of health care. The bill was strongly opposed by pharmaceutical manufacturers.

The Governor also signed two bills needed to align California law with recent federal regulations. Health plans and public hospitals negotiated for most of the year on a new financing mechanism, which was eventually amended into SB 171 by Senator Hernandez. The bill also included language establishing a medical loss ratio (MRL) of 85 percent for Medi-Cal managed care plans and requires a plan to remit any profits in excess of 15 percent. This matter will not impact County Organized Health Systems (COHS), as they all maintain an MRL well under 10 percent.

The second bill of the two-bill package signed into law was AB 205 by Assemblyman Wood. This bill establishes new time and distance standards to ensure healthcare network adequacy. AB 205 also includes new standards for plan grievances and appeals.

Finally, the Governor signed SB 323 by Senator Mitchell. The new law authorizes a federally qualified health center (FQHC) or rural health clinic (RHC) to enroll as a Drug Medi-Cal (DMC) certified provider and receive reimbursement for such services. It also allows a FQHC and RHC to contract with one or more mental health plans (MHP) that contract with DHCS to provide specialty mental health (SMH) services to Medi-Cal beneficiaries.

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2017–18 Legislative Tracking Matrix

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Action/Position
HR 601 (Lowey)	**Continuing Resolution (CR):** This bill extends current federal discretionary spending ($1.24 trillion overall) and raises the debt ceiling through December 8, 2017. The bill ensures funding for federal agencies such as the U.S. Department of Health and Human Services (HHS) continues at approximately $65 billion per year. Mandatory spending ($2.54 trillion overall) for program such as Medicare ($646 billion/year) and Medicaid ($545 billion/year) is not impacted by the CR.	**09/08/2017** Signed into law	Watch
HR 1628 (Black)	**ACA Repeal/Replace:** "Graham-Cassidy" would replace the Medicaid FMAP with per capita caps, repeal the Medicaid expansion by 2020, and combine state exchange and state Medicaid expansion dollars into a block grant. *Senate Amendment 271:* "Repeal Now, Replace Later" would repeal Medicaid expansion beginning in 2020. *Senate Amendment 270:* "Better Care Reconciliation Act" would replace Medicaid FMAP with per capita caps and phase-down federal funding for Medicaid expansion beginning in 2021. The American Health Care Act would make sweeping changes to the national health care system. For CalOptima, the most significant changes would be 1) Changes to the Medicaid financing structure from the FMAP to a per capita cap system, 2) Decreased federal dollars for Medicaid expansion members who leave and return to the program, 3) Additional state authority to set "essential health benefits" for Medicaid plans, and 4) Potentially decreased funding and additional restrictions for CMS waivers.	**09/26/2017** Senate leaders announce no vote **07/26/2017** Failed Senate **07/25/2017** Failed Senate **05/04/2017** Passed House, referred to Senate	Sent letter of opposition Sent letter of concern Sent letter of concern
HR 3168 (Tiberi)	**Five Year D-SNP Re-authorization:** This bill would, among other things, re-authorize dual eligible special needs plans (D-SNPs) for five years, including CalOptima's OneCare program. Historically, D-SNPs have been temporarily re-authorized by Congress, and are currently set to expire on December 31, 2018.	**07/13/2017** Passed House Committee on Ways and Means, referred to House floor	Sent letter of support
HR 3922 (Walden)	**Five Year CHIP Re-authorization:** This bill would extend federal CHIP funding, which expired on September 30, 2017, for five years. It would keep the current ACA mandated state/federal CHIP matching rate (88/12 for California) for two years, reduce it by 11.5 percent for one year (76.5/23.5), and revert to pre-ACA levels for two years (65/35). This bill also includes spending offsets such as increasing Medicare premiums for beneficiaries who make more than $500,000 annually, requires Medicaid beneficiaries to report lottery winnings as income, and decreases funding for the ACA-enacted Prevention and Public Health Fund.	**11/03/2017** Passed House, referred to Senate	Sent letter of support for CHIP re-authorization

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Action/Position
H. Concurrent Resolution 71 (Black)	**FY 18 Budget Resolution:** The annual budget resolution sets the budgetary framework for the upcoming fiscal year, and allows the majority party (Republicans) to pass reconciliation legislation by 51 votes in the Senate rather than the 60-vote threshold. While the budget resolution is non-binding and does not appropriate federal dollars, it does outline spending priorities for the remainder of the unfunded fiscal year (December 9, 2017 - September 30, 2018).	**10/26/2017** Passed House and Senate (Budget resolutions do not require a Presidential signature)	Watch
Bipartisan Health Care Stabilization Act of 2017 (Alexander/ Murray)	**Marketplace Stabilization:** This bill, through 2019, would fund cost-sharing reductions (CSRs), which are federal payments to marketplace insurers to reduce deductibles and co-pays for consumers earning between 139-250 percent of the FPL who have a "silver" level plan. This bill would also increase flexibility and streamline the state waiver approval process, allow all individuals to purchase "copper" (or catastrophic) plans, and requires HHS to allow plans to be sold across state lines. While this bill does not impact Medicaid directly, it is of interest to CalOptima because of its impact on the health care system, and, because it is common for Medicaid members to "churn" between Medicaid and the individual market.	**10/19/2017** Draft bill text released	Watch
S 191 (Cassidy)	**ACA Repeal/Replace:** The Patient Freedom Act would repeal several mandates in the Affordable Care Act (ACA), such as the individual and employer mandates, and the essential health benefit requirements. The bill retains most of the ACA consumer protections, such as prohibiting discrimination and pre-existing conditions exclusions. Once the ACA provisions are repealed, the bill would provide greater state flexibility for their Medicaid and exchange programs. Specifically, states would be given three options after the ACA provisions are repealed: 1) A state-specific health system (excluding the repealed ACA provisions) with 95 percent of current federal funding available to states, 2) A state-based health care system with no federal financial assistance, or 3) Continue under current system at funding no more than option one.	**01/23/2017** Referred to Senate Committee on Finance	Watch
S 870 (Hatch)	**Permanent D-SNP Re-authorization:** This bill would, among other things, permanently re-authorize dual eligible special needs plans (D-SNPs), including CalOptima's OneCare program. Historically, D-SNPs have been temporarily re-authorized by Congress, and are currently set to expire on December 31, 2018.	**09/26/2017** Passed Senate, referred to the House	Sent letter of support
S 1804 (Sanders)	**Medicare for All:** This bill would replace the current U.S. health care system with a single-payer system, known as Medicare for All. This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs, and enroll all eligible individuals into the new universal plan. No official financial analysis or CBO score is currently available.	**09/13/2017** Referred to Senate Committee on Finance	Watch
S 1827 (Hatch)	**Five Year CHIP Re-authorization:** This bill would extend federal CHIP funding, which expired on September 30, 2017, for five years. It would keep the current ACA mandated state/federal CHIP matching rate (88/12 for California) for two years, reduce it by 11.5 percent for one year (76.5/23.5), and revert to pre-ACA levels for two years (65/35). This bill does not currently include spending offsets.	**10/04/2017** Passed Senate Committee on Finance, referred to Senate floor	Sent letter of support for CHIP re-authorization

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Action/Position
AB 15 (Maienschein)	**Denti-Cal Rate Increase:** This bill would require the Department of Health Care Services (DHCS) to increase the Denti-Cal provider reimbursement rates to the regional commercial rates for the 15 most common dental services. While the bill does not specify a dollar amount for the increase, it does note Denti-Cal's low utilization and funding levels, citing the need for increased reimbursement rates to attract additional providers. CalOptima members who receive Denti-Cal benefits outside of CalOptima may be affected by this proposed increase in funding.	**05/26/2017** Held under submission	Watch
AB 97 (Ting)	**State Budget:** This bill enacts California's Budget for FY 17-18. The bill allocates $183.3 billion, $105 billion of which is for the Medi-Cal program.	**06/27/2017** Signed into law	Watch
AB 120 (Ting)	**State Budget:** This "junior budget bill" contains specific state Medi-Cal appropriations and budget instructions. Section 3(1)1-5 of the bill requires Proposition 56 revenue to include $325 million for increased Medi-Cal physician payments and $140 million for increased Denti-Cal provider payments. Most of the remaining Proposition 56 funds will be used for general Medi-Cal expenditures. Additionally, section 1(16) of the bill requires DHCS to provide Medicare Part A recoupment amounts to plans by July 31, 2017. This is a result of a state enrollment error, where some Medi-Cal members with Medicare Part A were incorrectly enrolled as Medi-Cal expansion members and were funded at a higher federal match. DHCS must return $365 million to the federal government and will collect payments from Medi-Cal health plans, including CalOptima.	**06/27/2017** Signed into law	Watch
AB 205 (Wood)	**Mega-Reg:** This bill would implement certain provisions of the CMS Medicaid managed care rules (Mega-Reg) by making changes at the state level regarding Medi-Cal managed care plans. Specifically, this bill would change the grievance and appeals process for plans by lengthening the amount of time members have to request a state fair hearing from 90 days to 120 days. It would also establish new time and distance standards for members to access primary and specialty care services.	**10/13/2017** Signed into law	Watch
AB 675 (Ridley-Thomas)	**IHSS Funding:** This bill would appropriate $650 million of state General Fund dollars to DHCS in order to allow In-Home Supportive Services (IHSS) to continue as a Medi-Cal managed care benefit. The Coordinated Care Initiative (CCI) contained a "poison pill" that went into effect in January, meaning IHSS will no longer be a Medi-Cal managed care benefit beginning January 1, 2018. This bill aims to retain the IHSS provision of CCI by shifting dollars from the state General Fund to DHCS.	**05/26/2017** Held under submission	Watch
AB 1074 (Maienschein)	**Behavioral Health Providers**: This bill expands the definition of autism service providers, potentially affecting CalOptima's behavioral health treatment (BHT) provider network.	**09/30/2017** Signed into law	Watch
SB 4 (Mendoza)	**CalOptima Board of Directors:** This bill codifies the current seat designations on the CalOptima Board of Directors, and modifies the Board member removal process.	**10/04/2017** Signed into law	Watch

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Action/Position
SB 97 (Committee on Budget and Fiscal Review)	**Cal MediConnect Extension, Medi-Cal Benefits:** This bill enacts the health care trailer bill language related to the state FY 17-18 budget bill. Most importantly for CalOptima, it extends the Cal MediConnect (CMC) program, including CalOptima's OneCare Connect program, until December 31, 2019. IHSS administration will be transferred back to the counties but will still remain available to OneCare Connect members. The bill also includes language that restores certain dental benefits on January 1, 2018 and certain Medi-Cal optical benefits on January 1, 2020.	**07/10/2017** Signed into law	Sent letters of support for Cal MediConnect Extension
SB 152 (Hernandez)	**CCS:** Based on the most recent guidance from DHCS, CalOptima will implement the Whole Child Model (WCM) no sooner than January 1, 2019. However, under current law, DHCS is required to submit a report to the Legislature no later than January 1, 2021 (2 years after plan implementation). Since the WCM implementation date has been delayed, this bill has been introduced to allow plans the full three years to implement the WCM before DHCS submits its report to the Legislature. This bill would also allow DHCS to make this report available to the public with 90 days instead of the original 30 days.	**07/17/2017** Ordered to inactive file	Watch
SB 171 (Hernandez)	**Meg-Reg:** This bill would implement certain provisions of the Mega-Reg by making changes at the state level regarding Medi-Cal managed care plans. Specifically, this bill would require plans to adopt an 85 percent medical loss ratio (MLR) by July 1, 2019. It would also require plans to modify their payment structures to designated public hospitals.	**10/13/2017** Signed into law	Watch
SB 223 (Atkins)	**Medi-Cal Languages:** This bill would require Medi-Cal managed care plans to notify members of their nondiscriminatory protections, and translate its member materials into the top 15 languages as identified by DHCS. Plans are currently required to translate materials into threshold languages based on regional population. It would also require interpreters to be deemed qualified by the state and receive additional ethics, conduct, and proficiency training.	**10/13/2017** Signed into law	Watch
SB 608 (Hernandez)	**Hospital QAF:** This bill will modify the hospital quality assurance fee to bring it into compliance with Mega-Reg requirements. The current language of the bill only reflects a portion of the California Hospital Association's proposal to reform the QAF. The bill's language is likely to be substantially amended in the next legislative session.	**09/01/2017** Held under submission	Watch

The CalOptima Legislative Tracking Matrix includes information regarding legislation that directly impacts CalOptima and our members. These bills are closely tracked and analyzed by CalOptima's Government Affairs Department throughout the legislative session. All official "Support" and "Oppose" positions are approved by the CalOptima Board of Directors. Bills with a "Watch" position are monitored by staff to determine the level of impact.

2017 Federal Legislative Dates

January 3	115th Congress convenes
January 20	Presidential Inauguration
April 10–21	Spring recess
July 28–September 1	Summer recess
September 30	CHIP funding expires under current law, pending Congressional action
September 30	2017 budget resolution expires
November 20–24	Fall recess
December 8	Federal appropriations expire

2017 State Legislative Dates

January 4	Legislature reconvenes
February 17	Last day for legislation to be introduced
April 28	Last day for policy committees to hear and report bills to fiscal committees
May 12	Last day for policy committees to hear and report non-fiscal bills to the floor
May 26	Last day for fiscal committees to report fiscal bills to the floor
May 30–June2	Floor session only
June 2	Last day to pass bills out of their house of origin
June 15	Budget bill must be passed by midnight
July 21–August 21	Summer recess
September 1	Last day for fiscal committees to report bills to the floor
September 5–15	Floor session only
September 15	Last day for bills to be passed. Interim recess begins
October 15	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2017 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

Board of Directors Meeting
December 7, 2017

CalOptima Community Outreach Summary — November 2017

Background

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

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

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

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

CalOptima Community Events Update

The Community Relations and Case Management departments hosted CalOptima's Community Resource Fair for CalOptima employees and health care partners on Tuesday, October 3, 2017, from 9 a.m. to 12 p.m. Approximately 250 employees and health care partners participated in this opportunity to network and learn about resources available to support our members who are seniors and people with disabilities.

Thirty-five community organizations were on-site to engage CalOptima employees and health care partners about programs and services available in Orange County. Feedback from evaluations indicated that attendees appreciated the variety of resources represented and valued the learning opportunity. One participant stated, "There is more interaction; best fair in 3 years. Vendors were more talkative, and I learned a lot." Another participant shared that he enjoyed the networking component and opportunity to learn about community resources he can access for personal use for his family saying, "The information is for my mom who is 80 years old; this is very specific to her needs." Participants expressed appreciation for information provided by Orange County Transportation Authority (OCTA), the City of Santa Ana, SeniorServ, 2-1-1 OC, Orange County Health Care Agency's – Adult and Older Adult

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Behavioral Health, and Orange County Office on Aging. We are extremely grateful to the organizations that participated and engaged with our staff and health care partners, including 30 health care partners from Monarch, Alta Med and Kaiser.

For additional information or questions, please contact Tiffany Kaaiakamanu, manager of Community Relations at **657-235-6872** or email tkaaiakamanu@caloptima.org.

Summary of Public Activities

During November, CalOptima participated in 42 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
11/02/17	• Homeless Provider Forum • Refugee Forum of Orange County
11/03/17	• Covered Orange County General Meeting
11/06/17	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting
11/07/17	• Collaborative to Assist Motel Families Meeting
11/08/17	• Buena Park Collaborative Meeting • Anaheim Homeless Collaborative Meeting
11/09/17	• FOCUS Collaborative Meeting • State Council on Developmental Disabilities Regional Advisory Committee Meeting
11/10/17	• Senior Citizen Advisory Council Meeting
11/13/17	• Orange County Veterans and Military Families Collaborative Meeting • Fullerton Collaborative Meeting
11/14/17	• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting • Buena Clinton Neighborhood Coalition Meeting • Susan G. Komen Orange County — Unidos Contra el Cancer del Seno Coalition Meeting • San Clemente Youth Wellness and Prevention Coalition
11/15/17	• Covered Orange County Steering Committee Meeting • Minnie Street Family Resource Center Professional Roundtable • Orange County Promotoras • La Habra Move More Eat Healthy Plan Meeting • Orange County Communication Workgroup

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	• Annual Meeting and Allied Conference hosted by California Association of Area Agencies on Aging (Registration Fee: $500 included one resource table at the event)
11/16/17	• Orange County Children's Partnership Committee Meeting • Orange County Women's Health Project Advisory Board Meeting • Annual Meeting and Allied Conference hosted by California Association of Area Agencies on Aging (Registration Fee: $500 included one resource table at the event)
11/21/17	• North Orange County Senior Collaborative All Members Meeting • Placentia Community Collaborative Meeting • Orange County Cancer Coalition Meeting
11/23/17	• Disability Coalition of Orange County • Orange County Care Coordination for Kids
11/27/17	• Stanton Collaborative Meeting • Orange County Senior Roundtable • Santa Ana Building Healthy Community Meeting
11/29/17	• Orange County Human Trafficking Task Force General Meeting

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff Attended	Events/Meetings
11/02/17	2	• 7th Annual Unidos Roundtable hosted by Susan G. Komen Orange County
	1	• Navigating Senior Resources in Orange County hosted by La Habra Community Center and Orange County Aging Services Collaborative
11/03/17	1	• Annual Resource Fair and Flu Shot Clinic hosted by Tustin Area Senior Center (Registration Fee: $25 included a table for outreach)
11/04/17	1	• Annual Alzheimer's Latino Conference hosted by Alzheimer's Orange County (Sponsorship Fee: $2,500 includes opportunity to give a welcome presentation to participants on behalf of the corporation during opening ceremony, acknowledgement in press releases and advertisements one month prior to conference [radio, magazine, website, and newspaper] corporate logo prominently placed around conference and on the agenda, corporate logo placed in looping video acknowledgments at the front entrance, information in goody bag, a table for outreach, lunch for two, and a certificate of recognition)
	1	• Annual Health and Wellness Fair hosted by Nhan Hoa Comprehensive Health Care Clinic
11/08/17	1	• Senior Week Health and Wellness Fair hosted by City of La Habra, Institute for Healthcare Advancement, and La Habra Collaborative (Registration Fee: $75 included one table for outreach)

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11/15/17	2	• Annual Meeting and Allied Conference hosted by California Association of Area Agencies on Aging (Registration Fee: $500 included one table for outreach)
11/17/17	1	• Transportation Awareness Day hosted by Laguna Woods Village (Sponsorship Fee: $500 included recognition on event flyer and event program, at event, one outreach table and opportunity to provide promotional items and door prizes at the event)
11/19/17	1	• Vietnamese Community Health Fair hosted by Vietnamese Community Health at UCLA

CalOptima organized or convened the following 18 community stakeholder events, meeting and presentations:

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
11/1/17	• Community-based organization for Silverado Hospice — Topic: CalOptima Overview
11/02/17	• CalOptima New Member Orientation for Medi-Medi Members (Vietnamese)
11/03/17	• County Community Service Center Health Education Seminar — Topic: Understanding Medicare: The Benefits and Options (Vietnamese)
11/06/17	• CalOptima collaborated with Health Care Agency Public Health Nurse to host Education Workshop — Topic: 40 Developmental Assets
11/07/17	• Community-based organization for Cambodian Family Resource Center — Topic: CalOptima Overview
11/08/17	• CalOptima New Member Orientation for Medi-Cal Members (Korean and Farsi)
11/09/17	• CalOptima New Member Orientation for Medi-Cal Members (Chinese and Arabic)
11/14/17	• CalOptima New Member Orientation for Medi-Cal Members (English and Spanish)
11/15/17	• CalOptima Health Education Seminar for Madison Elementary — Topic: In Our Own Voice
11/16/17	• CalOptima Health Education Workshop — Topic: Great American Smokeout • CalOptima Health Education Seminar for Clark Commons Residents — Topic: Stress Management
11/17/17	• County Community Service Center Health Seminar — Topic: Understanding OneCare Connect Cal MediConnect Program (Vietnamese)

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11/21/17	• CalOptima New Member Orientation for Medi-Cal Members (Chinese and Arabic)
11/23/17	• CalOptima New Member Orientation for Medi-Cal Members (Vietnamese)
11/29/17	• CalOptima New Member Orientation for Medi-Cal Members (Korean and Farsi)
11/30/17	• CalOptima New Member Orientation for Medi-Cal Members (English and Spanish)

CalOptima provided zero endorsements for events during this reporting period (e.g., letters of support, program/public activity event with support, or use of name/logo).

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CalOptima Board of Directors
Community Activities

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

December				
Friday, 12/1 9-10:30am	++Covered Orange County General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	The Village 1505 E. 17th St. Santa Ana
Friday, 12/1 9-10:30am	++Help Me Grow Advisory Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana
Monday, 12/4 1-4pm	++OCHCA Mental Health Services Act Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 12/5 9:30-11am	++Collaborative to Assist Motel Families	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Wednesday, 12/6 9-10:30am	++OC Aging Services Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 12/6 10am-12pm	++Anaheim Human Services Network	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Orange County Family Justice Center 150 W. Vermont Anaheim
Wednesday, 12/6 10:30am-12pm	++OC Healthy Aging Initiative	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Alzheimer's OC 2515 McCabe Way Irvine

+ Exhibitor/Attendee
++ Meeting Attendee

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Thursday, 12/7 9-11am	++Homeless Provider Forum	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Friday, 12/8 9:30am-11am	+Senior Citizen Advisory Council Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Location varies
Monday, 12/11 1-2pm	++Orange County Veterans and Military Families Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 12/11 2:30-3:30pm	++Fullerton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 12/12 9-11am	*Community Alliances Forum	**Community Presentation** **Open to the Public** ***Registration requested***	N/A	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 12/12 2-4pm	++Susan G. Komen Unidos Contra el Cancer del Seno Coalition	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Susan G. Komen OC 700 Newport Center Dr. Newport Beach
Tuesday, 12/12 4-5:30pm	++San Clemente Youth Wellness & Prevention Coalition	**Steering Committee Meeting: Open to Collaborative Members**	N/A	San Clemente High School 700 Avenida Pico San Clemente
Wednesday, 12/13 10-11:30am	++Buena Park Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Buena Park Library 7150 La Palma Ave. Buena Park
Wednesday, 12/13 12-1:30pm	++Anaheim Homeless Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Thursday, 12/14 11:30am-12:30pm	++FOCUS Collaborative Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Magnolia Park Family Resource Center 11402 Magnolia St. Garden Grove

+ Exhibitor/Attendee
++ Meeting Attendee

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Tuesday, 12/19 10-11:30am	++Placentia Community Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Placentia Presbyterian Church 849 Bradford Ave. Placentia
Wednesday, 12/20 9:15-11am	++Covered OC Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	N/A	The Village 1505 E. 17th St. Santa Ana
Wednesday, 12/20 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana
Wednesday, 12/20 1-4pm	++Orange County Promotoras	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Location varies
Wednesday, 12/20 1:30-3pm	++La Habra Move More Eat Health Plan	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Friends of Family Community Clinic 501 S. Idaho St. La Habra
Wednesday, 12/20 3:30-4:30pm	++Orange County Communications Workgroup	**Steering Committee Meeting: Open to Collaborative Members**	N/A	CalOptima
Thursday, 12/21 8:30-10am	++Orange County Children's Partnership Committee	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 12/21 1:30-2:30pm	++Surf City Senior Providers Network and Lunch	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Senior Center in Central Park
Thursday, 12/21 2:30-4:30pm	++Orange County Women's Health Project Advisory Board Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	The Village 1505 E. 17th St. Santa Ana
Tuesday, 12/26 7:30-9am	++OC Senior Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Orange Senior Center 170 S. Olive Orange

Tuesday, 12/26 3:30-4:30pm	++Santa Ana Building Healthy Communities	**Steering Committee Meeting: Open to Collaborative Members**	N/A	KidWorks 1902 W. Chestnut Ave. Santa Ana
Wednesday, 12/27 10:30-11:30am	++OC Human Trafficking Task Force General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Community Service Program 1221 E. Dyer Rd. Santa Ana
Thursday, 12/28 8:30-10am	++Disability Coalition of Orange County	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Dayle McIntosh Center 501 N. Brookhurst St. Anaheim
Thursday, 12/28 8:30-10am	++OC Care Coordination for Kids	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana